Proposed Standard Updates to 2025 Accreditation Programs

Health Plan Accreditation

Affected Standards and Elements

QI 3, Elements A–C	CR 2, Element A	CR 7, Elements A–E
UM 5, Elements A, B, E	CR 3, Elements A–I	CR 8, Elements A–D
UM 12, Elements A–G	CR 4, Element A	CR 9, Elements A–D
UM 13, Elements A–D	CR 5, Element A	
CR 1, Elements A, B	CR 6, Element A	

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QI 3: Continuity and Coordination of Care

The organization demonstrates continuity and coordination of care across the health care network and between medical and behavioral healthcare.

Intent

The organization demonstrates continuity and coordination of medical and behavioral healthcare across its delivery system.

Element A: Data Exchange for Continuity and Coordination of Care

The organization annually collects data on exchange of information related to continuity and coordination of care:

1. **Between medical practitioners.**

2. **Between medical and behavioral health practitioners.**

3. **Across settings.**

Summary of Changes

- This new element replaces former QI 3 and QI 4 from the Health Plan Accreditation 2024 standards and earlier.

Scoring

Met	Partially Met	Not Met
The organization meets 3 factors	No scoring option	The organization meets 0-2 factors

Data source Documented Process, Reports, Materials

Scope of review

Product lines

This element applies to:

- *Interim and First Surveys for the commercial, Medicare and Medicaid product lines*

- *Renewal Surveys for the commercial, Medicare and Medicaid product lines only for organizations that are not required to report Health Plan Ratings measures.*

- *All surveys for the Exchange product line.*

Documentation

For Interim Surveys: NCQA reviews the organization's annual plan to collect data on the exchange of information between medical practitioners, between medical and behavioral health practitioners and across settings.

For First Surveys: NCQA reviews the organization's exchange of information related to continuity and coordination of care.

For Renewal Surveys (Exchange product lines and commercial, Medicaid, Medicare product lines not required to report Health Plan Ratings measures): NCQA reviews the organization's exchange of information related to continuity and coordination of care for the most recent year.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: At least once during the prior year.

For Renewal Surveys (all Exchange product lines and commercial, Medicaid, Medicare product lines not required to report Health Plan Ratings measures): At least once during the prior year.

Explanation

The organization collects data on exchange of information related to continuity and coordination of care between medical practitioners, between medical and behavioral health practitioners and across settings as members' conditions and care needs change during the course of a chronic or acute illness.

Between practitioners includes the inception or cessation of patient care by a practitioner, and coordination of care across practitioners who are concurrently or intermittently providing ongoing care for members.

Across settings usually occurs as a member's health status changes (e.g., moving from home to hospital, moving from the hospital to a rehabilitation facility). Continuity and coordination of care across settings may occur between any setting type (e.g., medical to medical, medical to behavioral health).

Factors 1–3: **Exchange of information**

The exchange of information is bidirectional (i.e., information is exchanged by both parties).

The organization collects data on exchange of information between medical practitioners, between medical and behavioral health practitioners and across settings by measuring any or all of the following:

- Accuracy of information.
- Sufficiency of information.
- Timeliness of information.
- Clarity of information.
- Frequency of receiving information.

For factor 1, the organization meets the requirement if medical healthcare practitioners can access each other's notes through a fully integrated electronic medical record (EMR). NCQA considers an EMR to be fully integrated if it is implemented for all participating medical health care practitioners.

For factor 2, the organization meets the requirement if medical and behavioral healthcare practitioners have a fully integrated EMR. NCQA considers an EMR to be fully integrated if it is implemented across all participating medical and behavioral healthcare practitioners.

For factor 3, the organization meets the requirement if healthcare providers have a fully integrated EMR. NCQA considers an EMR to be fully integrated if it is implemented across all participating health care practitioners (medical and behavioral health practitioners) and providers. Both individual practitioners and facilities must have access to a fully integrated EMR to meet factor 3.

Exception

This element is NA for Renewal Surveys for the commercial, Medicare and Medicaid product lines, unless the organization is not required to report Health Plan Ratings measures (e.g., <15,000 members).

Related information

Note: This element is intended to prepare organizations to meet requirements in Element B in their next Renewal survey, if applicable.

Examples   **Exchange of information related to continuity and coordination of care**

Factor 1: Exchange of information between medical practitioners

- Practitioner surveys related to the exchange of information between primary care practitioners and OB-GYNs and other prenatal care practitioners about communication and coordination of care issues identified for members that are pregnant or postpartum.
- Consult reports shared between primary care practitioners and eye care professionals (optometrists and ophthalmologists) for diabetic patients that includes evaluation of receipt of reports and report completeness.

Factor 2: Exchange of information between medical and behavioral healthcare

- Surveys of behavioral healthcare practitioners and other medical practitioners about their satisfaction with the frequency/timeliness/content of information exchanged between the two parties.
- Evaluation of solicited or unsolicited practitioner reports on communication between behavioral healthcare practitioners and medical practitioners, including protection of privacy, for members identified as having a substance abuse or mental health disorder.

Factor 3: Exchange of information between settings

- Survey results evaluating the sufficiency of information shared between an ED and a long-term care facility.
- Reports of timeliness of information shared between an inpatient facility and a long-term care facility.

Element B: Demonstrating Performance on Continuity and Coordination of Care Measures

The organization demonstrates continuity and coordination of care through performance on the required HEDIS Health Plan Ratings measures.

Summary of Changes

- This new element replaces former QI 3 and QI 4 from the Health Plan Accreditation 2024 standards and earlier.

Scoring

Met	Partially Met	Not Met
An average rating of 3.0 or higher across **all** required measures	An average rating of less than 3.0 across **all** required measures	No scoring option

Note: NCQA will use a glidepath approach to increase scoring rigor.

Data source   Health Plan Ratings Scoresheet

Scope of review

Product lines

This element applies to Renewal Surveys for the commercial, Medicare and Medicaid product line.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

The score for the element is the average across all measures.

Documentation

NCQA reviews the organization's most recent year's Health Plan Ratings scoresheet to demonstrate if the organization met the specified average rating for the required HEDIS Health Plan Ratings measure(s) listed below.

Look-back period

For Renewal Surveys: Prior to the survey date.

Explanation

Health Plan Ratings measures

The organization must provide the Health Plan Ratings scoresheet for the most recent Health Plan Ratings year to determine the threshold met for scoring.

Note: *Organizations that are "Standards only" but choose to submit data and be rated for Health Plan Ratings will be scored for QI 3, Element B.*

Continuity and coordination of care

The organization must report all of the following Health Plan Ratings measures for each product line (commercial, Medicare, Medicaid) brought forward for Accreditation.

Commercial measures

- Eye Exam for Patients With Diabetes (EED)
- Prenatal and Postpartum Care (PPC)—Prenatal Rate
- Prenatal and Postpartum Care (PPC)—Postpartum Rate
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Coordination of Care
- Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate
- Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 days —Total Rate
- Initiation and Engagement of Substance Use Disorder Treatment (IET)— Engagement of SUD Treatment—Total Rate

Medicaid measures

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Follow-Up After Hospitalization for Mental Illness (FUH)—7 Days—Total Rate

- Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate
- Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total Rate
- Eye Exam for Patients With Diabetes (EED)
- Prenatal and Postpartum Care (PPC)—Prenatal Rate
- Prenatal and Postpartum Care (PPC)—Postpartum Rate
- Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 Days—Total Rate
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Medicare measures

- Eye Exam for Patients With Diabetes (EED)
- Initiation and Engagement of Substance Use Disorder Treatment (IET)—Engagement of SUD Treatment—Total Rate
- Transitions of Care (TRC)—Notification of Admission Rate
- Transitions of Care (TRC)—Notification of Discharge Rate
- Transitions of Care (TRC)—Patient Engagement Rate
- Transitions of Care (TRC)—Medication Reconciliation Rate
- Potentially Harmful Drug-Disease Interactions in Older Adults (DDE)—Total Rate
- Use of High-Risk Medications in Older Adults (DAE)—Rate 3—Total Rate
- Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)—65+ years Rate
- Fall Risk Management (FRM)
- Follow-Up After Hospitalization for Mental Illness (FUH)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7 days—Total Rate
- Follow-Up After High Intensity Care for Substance Use Disorder (FUI)—7 days—Total Rate
- Follow-Up After Emergency Department Visit for Substance Use (FUA)—7 days—Total Rate

Exception

This element is scored NA for the applicable product line if the organization is not required to report HEDIS (e.g., organizations with low enrollment that do not meet the 15,000-member threshold for reporting HEDIS) and chose not to be rated for Health Plan Ratings.

Refer to Table X in the Health Plan Accreditation *Policies and Procedures* for information about when HEDIS reporting is required by survey type.

Element C: Improving Performance on Continuity and Coordination of Care Measures

Organizations annually monitor performance and act on any required continuity and coordination of care HEDIS Health Plan Ratings measure in Element B for which it received a rating of 1 or "No Credit (NC)."

Summary of Changes

- This new element replaces former QI 3 and QI 4 from the Health Plan Accreditation 2024 standards and earlier.

Scoring

Met	Partially Met	Not Met
The organization improved all measures with a rating of 1 or NC from its prior survey to a rating of at least a 2	No scoring option	The organization did not improve all measures with a rating of 1 or NC from its prior survey to a rating of at least a 2

Data source Health Plan Ratings Scoresheet, Documented process

Scope of review

Product lines

This element applies to Renewal Surveys for the commercial, Medicare and Medicaid product line.

NCQA reviews and scores this element for each product line brought forward for Accreditation.

Documentation

NCQA reviews the organization's Health Plan Ratings scoresheet from the most recent year, and Health Plan Ratings scoresheets used for the organization's prior Accreditation survey.

For surveys on or between July 1, 2025, and June 30, 2026, NCQA will accept a documented improvement plan that addresses all measures with a rating of 1 or "NC" in lieu of Health Plan Ratings scoresheets demonstrating improvement.

Look-back period *For Renewal Surveys:* Prior to the survey date.

Explanation *For Health Plan Accreditation 2025, the organization's improvement plan must identify all measures with a 1 or NC on the most recent Health Plan Ratings scoresheet for each applicable product line, and document all actions it plans to take to improve each measure's rating.*

The plan must include:

- How the organization will monitor progress.
- Frequency of monitoring.
- Staff responsible for carrying out the improvement plan.

One action may be used to address all measures, if appropriate, as long as it is clear the action is applicable to all measures.

Exceptions

This element is NA:

- If the organization received an NA in Element B. Refer to the Exceptions in Element B for details.
- If the organization did not receive a rating of 1 or NC in any required HEDIS Health Plan Ratings measure, this element is NA.

UM 5: Timeliness of UM Decisions

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.

Intent

The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.

Element A: Notification of Nonbehavioral Healthcare Decisions

The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions:

1. **For ~~commercial and Exchange~~ urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~24~~ 72 hours of the request.**

2. ~~**For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**~~

2̲3. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**

3̲4. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.**

4̲5. **For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**

5̲6. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**

	Met	Partially Met	Not Met
Scoring	High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source   Records or files

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 nonbehavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period	*For First Surveys:* 6 months. *For Renewal Surveys:* 12 months.
Explanation	**THIS IS A MUST-PASS ELEMENT.**

This element applies to all nonbehavioral healthcare denial determinations resulting from medical necessity review (as defined in UM 1, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

Urgent request: A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, *or*
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, *or*
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Nonurgent request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Preservice request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Postservice request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

Reclassification of nonbehavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–5̲6̶: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when the notice was provided to the member and practitioner, as applicable.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision notification time frame under certain circumstances. Refer to *Related information.*

Exceptions

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

~~Factors 1, 4 are~~ <u>Factor 3 is</u> NA for the Medicare and Medicaid product lines.

~~Factors 2, 5 are~~ <u>Factor 4 is</u> NA for the commercial and Exchange product lines.

Related information

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner.

For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.

In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the time frame for urgent, preservice and postservice requests.

Extension conditions

~~Factor 1: Urgent concurrent requests for commercial and Exchange product lines.~~	• ~~The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.~~
	• ~~The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.~~
~~Factors 2, 3:~~ Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.	*For Medicare,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, *or* • The organization needs additional information, *and* 　– Documents that it made at least one attempt to obtain the necessary information. 　– Notifies the member or the member's authorized representative of the delay. The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, *or*
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

~~Factor 3:~~
Factor<u>s</u> 1, 2:
Urgent <u>concurrent and urgent</u> preservice requests for commercial and Exchange product lines.
	For commercial and Exchange, extensions are not allowed for urgent concurrent decisions.
	
	For urgent preservice, the organization may extend the time frame once due to lack of information, for 48 hours, under the following conditions:
	
	• Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, *and*
	
	• The organization gives the member or the member's authorized representative at least 48 hours to provide the information, *and*
	
	• The extension period, within which a decision must be made by the organization, begins on the sooner of:
	  − The date when the organization receives the member's response (even if not all of the information is provided), *or*
	  − The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

~~Factor 4:~~ Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.	If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions: • Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, *and* • The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information. • The extension period, within which a decision must be made by the organization, begins on the sooner of: − The date when the organization receives the member's response (even if not all of the information is provided), *or*

	– The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative. – The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

~~Factor 5:~~
Factor 4:
Nonurgent preservice requests for Medicare and Medicaid product lines.
	For Medicare, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:
	• The member requests an extension, *or*
	• The organization needs additional information, *and*
	  – Documents that it made at least one attempt to obtain the necessary information.
	  – Notifies the member or the member's authorized representative of the delay.
	
	The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.
	
	For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:
	• The member requests an extension, *or*
	• The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.
	
	The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

~~Factor 6:~~ Factor 5: Postservice requests for commercial, Exchange and Medicaid product lines.	If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions: • Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, *and* • The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information. • The extension period, within which a decision must be made by the organization, begins on the sooner of: – The date when the organization receives the member's response (even if not all of the information is provided), *or*

       – The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons.	In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.
- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

For Medicare, extensions are not allowed for postservice requests.

~~Factors 1–3:~~ Factors 1–2: Verbal notification of denials.	Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***
- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.
- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours

of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.

- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***

- The organization documents the date and time when the information was posted in the portal, ***and***

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if*:*

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***

- The organization documents the date and time when the information was posted in the portal, ***and***

- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), ***and***

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Examples **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame but the member or practitioner submits the request outside the time frame.

Element B: Notification of Behavioral Healthcare Decisions

The organization adheres to the following time frames for notification of behavioral healthcare UM decisions:

1. **For ~~commercial and Exchange~~ urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~24~~ 72 hours of the request.**

2. ~~**For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**~~

2~~3~~. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**

3~~4~~. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.**

4~~5~~. **For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**

5~~6~~. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.**

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source Records or files

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

NCQA reviews and scores this element for each product line brought forward for Accreditation; only the commercial and Exchange product line files may be combined.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews a random sample of up to 40 behavioral healthcare denial files resulting from medical necessity review for evidence of timeliness of notification.

Look-back period *For First Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element applies to all behavioral healthcare denial determinations resulting from medical necessity review (as defined in UM 1, Element A).

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of behavioral requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–6~~5~~: **Timeliness of notification**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

NCQA measures timeliness of notification from the date when the organization receives the request from the member or the member's authorized representative, even if the organization does not have all the information necessary to make a decision, to the date when it notifies the member and practitioner, as applicable.

The organization documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization documents the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

An organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

The organization may extend the decision time frame under certain circumstances. Refer to *Related information.*

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Exceptions to member notification. NCQA does not require the organization to notify a member of:

- An urgent concurrent denial.
- An urgent preservice denial.
- A postservice (retrospective) denial if the member is not at financial risk.

For urgent denials, NCQA considers the attending or treating practitioner to be acting as the member's representative. During the file review process, NCQA assesses whether the decision notification time frames to the practitioner were appropriate.

~~Factors 1, 4 are~~ <u>Factor 3 is</u> NA for the Medicare and Medicaid product lines.

~~Factors 2, 5 are~~ <u>Factor 4 is</u> NA for the commercial and Exchange product lines.

Related information

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner.

For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.

In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the decision-making time frame for urgent, preservice and postservice requests.

Extension conditions

~~Factor 1: Urgent concurrent requests for commercial and~~	• ~~The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to, or any time after, the expiration of the previously approved period or number of~~

~~Exchange product lines.~~	~~treatments. The organization may treat the request to extend urgent concurrent care as urgent preservice and send a decision notification within 72 hours.~~
	~~• The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.~~
~~Factors 2, 3:~~ Factors 1, 2: Urgent concurrent and urgent preservice requests for Medicare and Medicaid product lines.	*For Medicare,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, *or* • The organization needs additional information, *and* − Documents that it made at least one attempt to obtain the necessary information. − Notifies the member or the member's authorized representative of the delay. The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension. *For Medicaid,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, *or* • The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information. The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.
~~Factor 3:~~ Factors 1, 2: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.	<u>*For commercial and Exchange,* extensions are not allowed for urgent concurrent decisions.</u> For urgent preservice, the organization may extend the time frame once due to lack of information, for 48 hours, under the following conditions: • Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, *and* • The organization gives the member or the member's authorized representative at least 48 hours to provide the information, *and* • The extension period, within which a decision must be made by the organization, begins on the sooner of:

	— The date when the organization receives the member's response (even if not all of the information is provided), *or*
	— The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.
~~Factor 4:~~ Factor 3: Nonurgent preservice requests for commercial and Exchange product lines.	If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions: • Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, *and* • The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information. • The extension period, within which a decision must be made by the organization, begins on the sooner of: — The date when the organization receives the member's response (even if not all of the information is provided), *or* — The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative. The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.
~~Factor 5:~~ Factor 4: Nonurgent preservice requests for Medicare and Medicaid product lines.	*For Medicare,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, *or* • The organization needs additional information, *and* — Documents that it made at least one attempt to obtain the necessary information. — Notifies the member or the member's authorized representative of the delay. The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension. *For Medicaid,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, *or* • The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

~~Factor 6:~~
 	
Factor 5:
Postservice requests for commercial, Exchange and Medicaid product lines.
	If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions:
	
	• Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and***
	
	• The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information.
	
	• The extension period, within which a decision must be made by the organization, begins on the sooner of:
	   – The date when the organization receives the member's response (even if not all of the information is provided), ***or***
	   – The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.
	
	The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

Extension for other reasons.	In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions: • Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision. • Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision. *For Medicare,* extensions are not allowed for postservice requests.
~~Factors 1–3:~~ Factors 1–2: Verbal notification of denials.	Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below. • Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and*** • The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***

- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, ***and***
- The organization documents the date and time when the information was posted in the portal, ***and***
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, ***and***
- The organization must have an alternative method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if*:*

- The organization documents the member's agreement to receive electronic notifications via the portal, ***and***

- The organization documents the date and time when the information was posted in the portal, *and*
- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification)l, *and*
- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, *and*
- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Examples   **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame but the member or practitioner submits the request outside the time frame.

Element E: Interim: Policies and Procedures

The organization has written policies and procedures in place for the following time frames for timeliness of nonbehavioral healthcare, behavioral healthcare and pharmacy UM decision making:

1. **For ~~commercial and Exchange~~ urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within ~~24~~ 72 hours of receipt of the request.**

~~2.~~ ~~For Medicare and Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.~~

2~~3~~. **For Medicare Part B and Medicaid pharmaceutical urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**

3~~4~~. **For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**

4~~5~~. **For Medicare Part B and Medicaid pharmaceutical urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**

5~~6~~. **For commercial and Exchange nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of receipt of the request.**

6~~7~~. **For Medicare and Medicaid nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.**

7̶8̶. **For Medicare Part B pharmaceutical nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request.**

8̶9̶. **For Medicaid pharmaceutical nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request.**

9̶10̶. **For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of receipt of the request.**

10̶11̶. **For Medicare Part D urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of receipt of the request.**

11̶12̶. **For Medicare Part D nonurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of receipt of the request.**

12̶13̶. **For Medicare Part D postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of receipt of the request.**

	Met	Partially Met	Not Met
Scoring	The organization meets 10-1̶3̶ 12 factors	The organization meets 7-9 factors	The organization meets 0-6 factors

Data source   Documented process

Scope of review

Product lines

This element applies to all product lines for Interim Surveys.

Documentation

For Interim Surveys: NCQA reviews the organization's policies and procedures for nonbehavioral healthcare, behavioral healthcare and pharmacy UM decision making.

Look-back period

For Interim Surveys: Prior to the survey date.

Explanation

This element is a **structural requirement**. The organization must present its own documentation.

This element applies to all UM determinations resulting from medical necessity review, whether they are approvals or denials (as defined in UM 1, Element A).

Definitions used when classifying UM requests

The organization uses the definitions stated in Element A.

Reclassification of requests that do not meet the definition of "urgent." All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or postservice).

Factors 1–13: **Timeliness of decision making**

NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.

The organization's policies and procedures specify that it makes nonbehavioral healthcare, behavioral healthcare and pharmacy UM decisions within the time frames specified in factors 1–13.

Policies include information on the timeliness of notification decisions, which is measured from the date when the organization receives the request from the member or from the member's authorized representative, even if the organization does not have all the information necessary to make the decision to the date when the notice was provided to the member and practitioner, as applicable.

The organization's policies document the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM department.

For Medicare urgent requests only: NCQA measures timeliness of notification for urgent requests from the date when the appropriate department receives the request. The organization's policies document the date when the appropriate department receives the request, and the date of the decision notification, in the UM file.

If the organization sends written notice, NCQA uses the date on the notice as the notification date. If the organization does not retain copies of the written notice, it has other methods of documenting the notification date. If the organization uses electronic notification, NCQA uses the date when the notification was posted in the electronic system.

The organization may have procedures for ongoing review of urgent concurrent care it approved initially. For ongoing reviews, the notification period begins on the day of the review. The organization documents the date of the ongoing review and the decision notification in the UM denial file.

Exceptions

Factors ~~1–10~~ 1–9 are NA for Medicare Part D drugs.

~~Factors 1 and 6 are~~ Factor 5 is NA for Medicare and Medicaid product lines.

~~Factors 3 and 5~~ Factors 2 and 4 are NA for pharmaceuticals under the commercial and Exchange product lines.

~~Factors 2 and 7 are~~ Factor 6 is NA for commercial and Exchange product lines.

~~Factor 8~~ Factor 7 is NA for pharmaceuticals under the commercial, Medicaid and Exchange product lines.

~~Factor 9~~ Factor 8 is NA for pharmaceuticals under the commercial, Medicare and Exchange product lines.

~~Factors 11–13~~ Factors 10–12 are NA for commercial, Medicaid and Exchange product lines and for Medicare Part B drugs.

Related information

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner.

For urgent concurrent decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.

In all cases, if the practitioner is not known, the organization must address the notification to the attention of the attending or treating practitioner; the practitioner name is not required.

Receiving requests after normal business hours. Due to the nature of urgent requests, the organization has procedures for accepting them after normal business hours. NCQA counts the time from the date when the organization receives the request, whether or not it is during business hours.

Postservice payment disputes. Postservice requests for payment initiated by a practitioner or a facility are not subject to review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not at financial risk). Exclude denials of such requests from the file review universe.

Approving alternative services. If the organization approves an alternative to the service being requested and the member or the member's authorized representative does not request or agree to the alternative service, the organization would be denying care that was originally requested; therefore, this is considered a denial and should be included in the file review universe. However, if the member or the member's authorized representative agrees to the alternative and the care is authorized, the member or the member's authorized representative has essentially withdrawn the initial request; therefore, this is not considered a denial and should not be included in the file review universe.

Extending time frames. Members or their authorized representatives may agree to extend the time frame for urgent, preservice and postservice requests.

Extension conditions

~~Factor 1: Urgent concurrent requests for commercial and Exchange product lines.~~	• ~~The organization may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to the expiration of the previously approved time period or number of treatments. The organization may treat the request as urgent preservice and send a decision notification within 72 hours.~~
	• ~~The organization may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the organization and the organization documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.~~
<u>Factors 2–5</u>~~4~~<u>: Urgent concurrent and urgent preservice requests for Medicare and Medicaid</u> product lines.	*For Medicare,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions: • The member requests an extension, ***or*** • The organization needs additional information, ***and*** – Documents that it made at least one attempt to obtain the necessary information.

– Notifies the member or the member's authorized representative of the delay.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:

- The member requests an extension, *or*
- The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Factor 4: Urgent concurrent and urgent preservice requests for commercial and Exchange product lines.	*For commercial and Exchange,* extensions are not allowed for urgent concurrent decisions.
	
	The organization may extend the urgent preservice time frame once due to lack of information, for 48 hours, under the following conditions:
	
	- Within 24 hours of receipt of the urgent preservice request, the organization asks the member or the member's representative for the information necessary to make the decision, *and*
	- The organization gives the member or the member's authorized representative at least 48 hours to provide the information, *and*
	- The extension period, within which a decision must be made by the organization, begins on the sooner of:
	  – The date when the organization receives the member's response (even if not all of the information is provided), *or*
	  – The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative.

Factor 6: Nonurgent preservice requests for commercial and Exchange product lines.	If the request lacks clinical information, the organization may extend the nonurgent preservice time frame for up to 15 calendar days, under the following conditions: - Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, *and* - The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information. - The extension period, within which a decision must be made by the organization, begins on the sooner of:

    – The date when the organization receives the member's response (even if not all of the information is provided), ***or***

    – The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

<u>Factors 7, 9: Nonurgent preservice requests for Medicare and Medicaid product lines.</u>	*For Medicare,* the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:
	
	• The member requests an extension, ***or***
	• The organization needs additional information, ***and***
	   – Documents that it made at least one attempt to obtain the necessary information.
	   – Notifies the member or the member's authorized representative of the delay.
	
	The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.
	
	For Medicaid, the organization may extend the time frame once, by up to 14 calendar days, under the following conditions:
	
	• The member requests an extension, ***or***
	• The organization needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.
	
	The organization notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

<u>Factor 10: Postservice requests for commercial, Exchange and Medicaid product lines.</u>	If the request lacks clinical information, the organization may extend the postservice time frame for up to 15 calendar days, under the following conditions: • Before the end of the time frame, the organization asks the member or the member's representative for the information necessary to make the decision, ***and*** • The organization gives the member or the member's authorized representative at least 45 calendar days to provide the information. • The extension period, within which a decision must be made by the organization, begins on the sooner of:

    − The date when the organization receives the member's response (even if not all of the information is provided), *or*

    − The last date of the time period given to the member to supply the information, even if no response is received from the member or the member's authorized representative.

The organization may deny the request if it does not receive the information within the time frame, and the member may appeal the denial.

<u>Extension for other reasons.</u>

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and postservice time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

- Within 30 calendar days of a postservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

<u>Extending time frames for Medicare Part B and D for factors 3, 5, 8, 11–13—Alignment with CMS.</u>

In accordance with the Medicare Prescription Drug Manual, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, extensions are not allowed.

For Medicare, extensions are not allowed for postservice requests.

<u>Factors 1–5: Verbal notification of denials.</u>

Verbal notification does not replace electronic or written notification of denial decisions, but when provided, the organization may extend the time frame for electronic or written notification for commercial, Medicare and Exchange decisions as described below.

- Verbal notification requires communication with a live person; the organization may not leave a voicemail, ***and***

- The organization records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***

- The organization provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request.

For commercial, Medicare and Exchange decisions, if the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification.

For Medicaid decisions, providing verbal notification does not extend the electronic or written notification time frame.

For Medicare Part D drugs, initial verbal notification of a decision may be made within the specified time frames. Written notification must be made no later than 3 calendar days after verbal notification.

Failure to follow filing procedures. If the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures for requesting preservice or urgent concurrent coverage, the organization notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.

- *For urgent preservice and concurrent decisions*, the organization notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.

- *For nonurgent preservice decisions*, the organization notifies the member or the member's authorized representative within 5 calendar days of receiving the request.

The organization may not deny a nonurgent preservice, urgent preservice or urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

The organization may deny a postservice request without conducting a medical necessity review—even if a medical necessity review is required (as outlined in UM 1, Element A)—if the member (or the member's authorized representative) does not follow the organization's reasonable filing procedures. The organization must provide the reason for the denial.

Use of practitioner web portals. The organization may provide electronic denial notifications to practitioners through a web portal if:

- The organization informs practitioners of the notification mechanism and their responsibility to check the portal regularly, *and*

- The organization documents the date and time when the information was posted in the portal, *and*

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include a site description that gives readers a clear idea of its topic and general content, *and*

- The organization has an alternative notification method for practitioners who do not have access to the web portal.

Use of member web portals. The organization may provide electronic denial notifications to members through a web portal if*:*

- The organization documents the member's agreement to receive electronic notifications via the portal, *and*

- The organization documents the date and time when the information was posted in the porta, *and*

- Members receive notification that a new document or update is available in the portal when it is posted (e.g., text, email, other electronic notification), *and*

- The information posted in the portal meets the requirements in UM 4–UM 7. If the portal contains a link to the information on a specific site, it must include

a site description that gives readers a clear idea of its topic and general content, ***and***

- The organization has an alternative notification method for members who do not have access to the web portal or who do not agree to receive notifications via the portal.

Examples   **Failure to follow filing procedures**

- An organization's procedure is that members or practitioners submit UM requests in writing but the member or practitioner files a request over the phone.
- An organization's procedure is that members or practitioners submit requests within a specific time frame but the member or practitioner submits the request outside the time frame.

UM 12: UM Information Integrity

The organization has UM information integrity policies, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.

Intent

The organization demonstrates its commitment to protecting the integrity of UM information used in in the processing of UM denials and UM appeals.

Element A: Protecting the Integrity of UM Denial Information

The organization has UM denial information integrity policies and procedures that specify:

1. **Scope of UM information.**

2. **Staff responsible for completing UM activities.**

3. **The process for documenting updates to UM information.**

4. **Inappropriate documentation and updates.**

5. **The process for documenting and reporting identified information integrity issues.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process,

Scope of review

Product lines

This element applies to Interim Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for protecting the integrity of UM information.

Look-back period   *For All Surveys:* Prior to the survey date.

Explanation   This element may not be delegated.

This element applies to UM information (both paper and electronic) used in the UM denial process (UM 4–UM 7).

UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process (UM 4–UM 7) against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures may be separate or may be incorporated in other organizational policies and procedures.

Factor 1: **Scope of UM information**

The organization's policies and procedures specify that the organization protects the integrity of the following UM information:

- Requests from the member or the member's authorized representative.
- Documentation of UM request receipt date.
- Documentation of appropriate practitioner review.
- Documentation of use of board-certified consultants.
- Documentation of clinical information.
- UM decision
- Documentation of UM decision notification date.
- Denial notice.

The organization defines the dates of receipt and written notification for UM denial determinations resulting from medical necessity review, consistent with requirements in UM 5.

Factor 2: **Staff responsible for performing** UM activities

The organization's policies and procedures:

- Specify titles of staff who are:
  – Responsible for documenting completion of UM activities.
  – Authorized to modify (edit, update, delete) UM information.
    ▪ Policies and procedures state if no staff are authorized to modify dates under any circumstances.
  – Responsible for oversight of UM information integrity functions, including the audit.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updating UM information is appropriate (e.g., the member sends an updated request).
- Describe the organization's process for documenting the following when updates are made to UM information:
  – When (e.g., date and time) the information was updated.
  – What information was updated.
  – Why the information was updated.
  – Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates to UM information are inappropriate:
  – Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
  – Creating documents without performing the required activities.
  – Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
  – Attributing review to someone who did not perform the activity (appropriate practitioner review).

– Updates to information by unauthorized individuals.

Factor 5: Auditing, documenting and reporting information integrity issues

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates.
  - The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified, and to
  - NCQA, when it identifies fraud and misconduct.
    - Refer to Section 5 *(Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events)* in the Policies and Procedures for additional details.
  - Specify consequences for inappropriate documentation and updates.

Exceptions

None.

Examples   None.

Element B: Protecting the Integrity of UM Appeal Information

The organization has UM appeal information integrity policies and procedures for:

1. The scope of UM information.

2. Staff responsible for performing UM activities.

3. The process for documenting updates to UM information.

4. Inappropriate documentation and updates.

5. The process for documenting and reporting information integrity issues, when identified.

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process

Scope of review

Product lines

This element applies to Interim Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for protecting the integrity of UM appeal information.

Look-back period

For All Surveys: Prior to the survey date.

Explanation   This element may not be delegated.

This element applies to UM information (both paper and electronic) used in the appeal process (UM 8–UM 9).

UM appeal information integrity refers to maintaining and safeguarding information used in the UM appeal process against inappropriate documentation and updates.

The organization's UM information integrity policies and procedures may be separate or may be incorporated in other organizational policies and procedures.

Factor 1: **Scope of UM information**

The organization's policies and procedures specify that the organization protects the integrity of the following UM information:

- Request from the member or the member's authorized representative.
- Documentation of the appeal request receipt date.
- Documentation of the substance and investigation of the appeal.
- Documentation of appeal participants, as applicable.
  – Individual or group (e.g., panel) deciding the appeal.
  – Appropriate practitioner.
  – Same-or-similar-specialist review.
- Appeal notice.
- Documentation of the appeal decision notification date.

The organization defines the dates of receipt and written notification for UM appeal decisions regarding coverage, whether or not a denial resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

The organization's UM information integrity policies and procedures may be separate, or may be incorporated in other organization policies and procedures.

Factor 2: **Staff responsible for performing UM activities**

The organization's policies and procedures:

- Specify titles of staff who are:
  – Responsible for documenting completion of UM activities.
  – Authorized to modify (edit, update, delete) UM information.
    ▪ Policies and procedures state if no staff are authorized to modify dates under any circumstances.
  – Responsible for oversight of UM information integrity functions, including the audit.

Factor 3: **Process for documenting updates to UM information**

The organization's policies and procedures:

- Specify when updating UM information is appropriate (e.g., the member sends an updated request).
- Describe the organization's process for documenting the following when updates are made to UM information:
  – When (e.g., date and time) the information is updated.
  – What information was updated.
  – Why the information was updated.
  – Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following are documentation and updates are inappropriate:
  – Falsifying UM dates (e.g., receipt date, appeal decision date, appeal notification date).
  – Creating documents without performing the required activities.
  – Altering existing documents (e.g., investigation information, same-or-similar specialist review, appeal notices).
  – Attributing review to an individual who did not perform the activity.
  – Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits UM staff documentation and updates. The organization does not have to include the audit methodology but must indicate that an annual audit will be performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  – The organization's designated individual(s) when identified, and to
  – NCQA, when it identifies fraud and misconduct.
    ▪ Refer to Section 5 *(Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events)* in the Policies and Procedures for additional details.
  – Specify consequences for inappropriate documentation and updates.

Exception

This element is NA for First Surveys and Renewal Surveys.

Examples   None.

Element C: Information Integrity Training

The organization trains UM staff on the following, upon hire and annually thereafter:

1. **Inappropriate documentation and updates (Element A, factor 4).**

2. **Organization audits of staff, documenting and reporting information integrity issues (Element A, factor 5).**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization does meets 0-1 factors

Data source   Reports, Materials

Scope of review Product lines

This element applies to all surveys for all product lines.

Documentation

For All Surveys, NCQA reviews training materials and reports demonstrating that the organization conducted the required trainings for UM staff upon hire and annually .

Look-back period

For First and Renewal Surveys: At least once during the prior year.

Explanation

This element may not be delegated.

Factor 1: **Inappropriate documentation and updates**

The organization trains UM staff on inappropriate documentation and updates to UM information, as defined in Element A, factor 4.

Factor 2: **Auditing, documenting and reporting information integrity issues**

The organization's training informs UM staff of:

- Organization audits of staff documentation and updates in UM files.
- The process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
- The consequences for inappropriate documentation and updates.

Exceptions

None.

Examples

None.

Element D: Audit and Analysis—Denial Information

The organization annually:

1. **Audits for inappropriate documentation and updates to UM denial receipt and notification dates.**

2. **Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source

Reports

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys: NCQA reviews the organization's audit and analysis reports completed during the look-back period.

Look-back period	*For All Surveys:* At least once during the prior year.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element may not be delegated.

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM request receipt dates (UM 5).
- UM denial decision notification dates (UM 5, UM 7).

The organization defines the dates of receipt and written notification for UM denial determinations resulting from medical necessity review, consistent with the requirements in UM 5.

The audit universe includes files for UM denial decisions made during the look-back period. The organization randomly samples and audits 5% or 50 files, whichever is less, from the file universe. The organization may choose to audit more UM denial files than NCQA requires.

The organization provides an auditing and analysis report that includes:

- The report date.
- The title of individuals who conducted the audit.
- The auditing methodology.
  - Auditing period.
  - Audit universe size.
  - Audit sample size.
- The file identifier (case number).
- The type of dates audited (i.e., receipt date, notification date).
- Findings for each file.
  - A rationale for inappropriate documentation or inappropriate updates.
- The number or percentage and total number or percentage of inappropriate findings by date type.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: Qualitative analysis

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report includes:

- Titles of UM staff involved in the analysis.
- The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exceptions

This element is NA for *Interim Surveys.*

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Examples   **Excerpt of an audit and analysis report**

Factor 1: **Annual sampling**

Each January, the organization's UM director audits for inappropriate documentation and updates to UM denial receipt dates (UM 5) and notification dates (UM 7) for the previous calendar year.

The organization randomly samples and audits 5% or 50 files (whichever is less) for all UM denial decisions made in the previous year.

Identify the universe. The organization made 1,500 UM denial decisions based on medical necessity review in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM denial files.

Calculate the sample size. Multiply the total number of UM denials files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample: 50 files.

Audit the selected sample. Audit the files for inappropriate documentation and updates, and documents findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 2:59 PM
1255	No	NA	NA
1265	No	NA	NA
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. on 3/3/XX @ 4:00 PM

Factors 1, 2: **Audit report and analysis**

Methodology

- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM denial files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM request receipt date	35	15	30%
UM denial notification date	35	15	30%
Total	35	15	30%

Qualitative analysis. The UM analyst provided the UM director with the audit log documenting when, how, why and by whom files were updated.

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM denial receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM request receipt date	All 15 receipt dates were improperly updated in the UM denial file by the same staff on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.
UM denial notification date	All 15 notification dates were improperly updated by the same staff on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Element E: Improvement Actions—Denial System Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element D.**

2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Reports, Materials

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys:
- *For factor 1:* NCQA *reviews* the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period   *For First and Renewal Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

The organization addresses UM information integrity issues identified in Element D.

Factor 1: **Implement corrective actions**

The organization documents all actions taken or planned, including the time frame for actions, to address all inappropriate documentation and updates (findings) identified in Element D. One action may address more than one finding, if appropriate. The organization may not use the annual trainings (Element C) as the only action.

The organization identifies the staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element D. The audit universe includes 3–6 months of UM denial files processed by the delegate since the annual audit completed for Element D.

The organization conducts an qualitative analysis if it identifies integrity during the follow-up audit.

The organization draws conclusions about the actions' overall effectiveness.

Exceptions

This element is NA for *Interim Surveys.*

This element is NA if the organization did not identify any inappropriate documentation and updates to UM denial receipt and decision notification dates. This must be evident in reports reviewed for Element D.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Examples   **Excerpt from report on corrective actions and measures of effectiveness**

Factor 1: **Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date]
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Establish process for two-step verification of system dates to records/information prepared for external review bodies.

Factor 2: **Effectiveness of corrective actions audit**

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology
- Audit staff: Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM denial files from January–December of the previous year.

Sample calculation
- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.

- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM request receipt date	50	0	0%
UM denial notification date	50	0	0%
Total	0	0	0%

Conclusions about the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial files on 3/3/XX, after a decision had been sent.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date]	Leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [date]
UM denial notification dates: UM staff member improperly updated decision notification dates in 15 UM denial files on 3/3/XX, after a decision had been sent.	Update UM system to read only records for dates and other UM information. [Date]. Establish process for two-step verification of system dates to records/information prepared for external review bodies.	The UM system was updated to read only records on [date]. Implemented two-step verification process on [date] and ran a "real-world scenario" test for informational purposes on [date].

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

Element F: Audit and Analysis—Appeal Request Dates and Notification

The organization annually:

1. **Audits for inappropriate documentation and updates to UM appeal receipt and notification dates.**

2. **Conducts qualitative analysis of inappropriate documentation and updates to UM appeal receipt and decision notification dates.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Reports

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.
Documentation

For First and Renewal Surveys: NCQA reviews the organization's audit and analysis report(s) completed during the look-back period.

Look-back period

For All Surveys: At least once during the prior year.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element may not be delegated.

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Audit**

The organization annually audits for inappropriate documentation and updates to:

- UM appeal request receipt dates.
- UM appeal decision notification dates.

The organization defines the dates of receipt and written notification for UM appeal decisions of coverage, whether or not an appeal resulted from medical necessity review, consistent with the requirements in UM 8 and UM 9.

The audit universe includes files for UM appeal decisions during the look-back period. The organization randomly audits a sample of UM appeal files from the audit universe using 5% or 50 files, whichever is less. The organization may choose to audit more UM appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- The title of staff who conducted the audit.
- The audit method:
  - Audit period.
  - Audit universe size.
  - Audit sample size.
  - File identifier (case number).
  - Type of date audited (receipt date, notification date).
- Findings for each file.
  - A rationale for inappropriate documentation or updates.
- The number or percentage and total inappropriate documentation and updates.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: **Qualitative analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause. Analysis involves staff responsible for executing the UM denial or appeal process.

The organization's auditing and analysis report includes:

- Titles of UM staff involved in the analysis.
- The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exceptions

This element is NA for *Interim Surveys.*

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Examples   **Excerpt from an audit and analysis report**

Factor 1: **Audit sampling**

Each January, the organization's UM director audits for inappropriate documentation and updates to UM 8–UM 9:

- UM appeal request receipt dates.
- UM appeal decision notification dates.

The organization randomly samples and audits 5% or 50 files (whichever is less) of all UM appeal decisions made in the previous year.

Identify the universe. The organization made 1,500 UM appeals decisions related to coverage or rescission of coverage in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM appeal files.

Calculate the sample size. Multiply the total number of UM appeal files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample: 50 files.
Audit the selected sample. Audit the files for inappropriate documentation and updates, and document findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because expedited appeal decision time frame had passed. 3/3/XX @ 2:59 PM
1255	No	NA	NA
1265	No	NA	NA
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because appeal decision

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
			notification time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent appeal decision notification time frame had passed. on 3/3/XX @ 4:00 PM

Factors 1, 2: **Audit report and analysis**

Methodology

- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM appeal files from January–December of the previous year.
- Auditor: UM director.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Date Type	Compliant Appeal Files	Noncompliant Appeal Files	Percentage of Noncompliant Appeal Files
UM appeal request receipt date	35	15	30%
UM appeal decision notification date	35	15	30%
Total	35	15	30%

Qualitative analysis. The UM analyst provided the UM director with the audit log documenting when, how, why and by whom files were updated.

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM appeal receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 appeal receipt dates were improperly updated in the UM appeal file by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

UM appeal decision notification date	All 15 appeal decision notification dates were improperly updated by the same staff on 5/3/XX, after a decision had been sent.	Notification dates were improperly updated because the expedited appeal time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Element G: Improvement Actions—Appeal Information

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element F.**

2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3–6 months after completion of the annual audit for Element F.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Reports, Materials

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys:

- *For factor 1:* NCQA reviews the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period   *For First and Renewal Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

This element applies to UM information (both paper and electronic) used in the UM appeal process (UM 8, UM 9).

Factor 1: **Implement corrective actions**

The organization documents all actions taken or planned to address all inappropriate documentation and updates (findings) identified in Element F. One action may be address more than one finding, if appropriate. The organization may not use annual training (Element C) as the only action.

The organization identifies staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure of effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element F, and draws conclusions about the actions' overall effectiveness. The audit universe includes 3–6 months of UM appeal files processed since the annual audit.

The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Exceptions

This element is NA for *Interim Surveys.*

This element is NA if the organization did not identify any inappropriate documentation and updates. This must be evident in reports reviewed for Element F.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Examples   **Excerpt from report on corrective actions and measures of effectiveness**

Factor 1: **Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Update UM system to read only records for dates and other UM information. [Date].
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Decision notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Establish process for two-step verification of system dates to records/information prepared for external review bodies.

Factor 2: **Effectiveness of corrective actions audit**

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings from the previous annual audit.

Methodology

- *Audit staff:* Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM appeal files using NCQA "5% or 50 files" method.
- Universe: All UM appeals files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	**0**	**0**	**0%**

Conclusions about the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Organization's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date]	Leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [Date]
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Update UM system to read only records for dates and other UM information. [Date]. Establish process for two-step verification of system dates to records/information prepared for external review bodies.	The UM system was updated to read only records on [Date]. Implemented two-step verification process on [Date] and ran a test real-world scenario for information purposes [Date]

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

UM 13: Delegation of UM

If the organization delegates UM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated UM activities and for protecting UM information integrity.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**

2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**

3. **Requires at least semiannual reporting by the delegated entity to the organization.**

4. **Describes the process by which the organization evaluates the delegated entity's performance.**

5. **Describes the process for providing member experience and clinical performance data to delegates when requested.**

6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

	Met	Partially Met	Not Met
Scoring	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source   Documented process, Materials

Scope of review

Product lines

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

Documentation

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For factor 4:

- New delegation agreements implemented on or after July 1, 2025, must address the delegate's UM information integrity.
- Delegation agreements in place prior to July 1, 2025, that address the system controls under the 2022–2024 standards do not need to be updated to address UM information integrity requirements. NCQA does not evaluate the agreement against system controls requirements in prior years.

- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated to address UM information integrity requirements.

For factor 6: Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in the factor. For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process required in factor 5. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months for factors 1–6.

For Renewal Surveys: 24 months for factors 1–6.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period. The delegation agreement describes all delegated UM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Delegation agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the UM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other UM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- The information reported by the delegate about delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited or NCQA-Certified delegates.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance, as required in Element C, including UM information integrity.

UM denial and appeal information integrity refers to maintaining and safeguarding information from inappropriate documentation and updates as outlined in UM 12, Elements A and B, factor 4.

If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the delegate protects the integrity of UM information used in the denial and appeal processing, as applicable. The delegation agreement specifies that the following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without completing the required activities or altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not complete the activity (appropriate practitioner review).
- Updating information by unauthorized individuals.

Factor 5: **Providing member and clinical data**

The organization's delegation agreement describes how the delegate obtains the following information upon request or on an ongoing basis:

- *Member experience data:* Complaints, CAHPS survey results or other data on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization.
  - The organization may provide data feeds for relevant claims data or clinical performance measure results.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exceptions

This element is NA if the organization does not delegate UM activities.

Factor 3 is NA for mail service organization delegates that only perform annual distribution (e.g., UM 11, Element B). Factor 3 is not NA for distribution that occurs more frequently than annually (e.g., denial and appeal notices).

Factor 5 is NA for mail service organization delegates.

Factor 7 is NA if the organization does not delegate UM medical necessity activities (UM 4–UM 7) and does not delegate UM appeal activities (UM 8, UM 9).

Related information

Outsourcing UM data storage to a cloud-based entity. It is not considered delegation if the organization only outsources UM data storage to a cloud-based entity that does not provide services that create, modify or use the UM data.

Examples   *Factor 3:* **Reporting for delegation of UM denials and appeals**

- Number of UM cases handled by type (preservice, urgent concurrent, postservice) and by service (inpatient or outpatient).
- Number of denials issued.
- Number of denials appealed.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source   Reports

Scope of review   **Product lines**

This element applies to all product lines for Interim Surveys, First Surveys and Renewal Surveys.

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period   *For Interim Surveys and First Surveys:* 6 months.

For Renewal Surveys: 12 months.

Explanation   This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless delegated UM requirements were not in scope or were scored NA during the delegates' NCQA survey.

Note: For organizations that have both NCQA-Accredited and non-Accredited delegates:

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes, and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional UM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool, and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples   **Predelegation evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of the UM Program

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's UM program.**

2. **Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect.**

3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**

4. **Semiannually evaluates regular reports, as specified in Element A.**

5. <u>**Annually audits each delegate's UM denial and appeal files for inappropriate documentation and inappropriate updates to request receipt dates and decision notification dates.**</u>

6. <u>**Implements a corrective actions for each delegate that addresses all inappropriate documentation and inappropriate updates to request receipt dates and decision notification dates found in factor 5.**</u>

7. <u>**Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.**</u>

Scoring

Met	Partially Met	Not Met
<u>The organization meets 6-7 factors</u>	<u>The organization meets 4-5 factors</u>	<u>The organization meets 0-3 factors</u>

Data source   Reports

Scope of review

Product lines

Factor 1 applies to Interim Surveys for all product lines.

All factors in this element apply to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or from all delegates if the organization has fewer than four.

For All Surveys: NCQA reviews the organization's evaluation of the delegate's UM program (factor 1).

For First Surveys: <u>NCQA also reviews the organization's most recent semiannual evaluation, annual review, audits, performance evaluation, corrective actions and measure of effectiveness (factors 2–7).</u>

For Renewal Surveys:

- *Factors 2–4:* NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.
- *Factors 5–7:* <u>NCQA also reviews the organization's most recent annual audit, performance evaluation, corrective actions and measure of effectiveness.</u>

The score for the element is the average of the scores for all delegates.

Look-back period	*For Interim Surveys and First Surveys:* Once during the prior year.
	For Renewal Surveys: 24 months for factors 1–4; <u>at least once during the prior year for factors 5–7.</u>
Explanation	This element may not be delegated.

NCQA-Accredited delegates

Automatic credit is available for factors 2 and 3 if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless delegated UM requirements were not in scope or were scored NA during the delegates' NCQA survey.

<u>Automatic credit is available for factors 5–7 if the organization all delegates are NCQA Accredited under the 2025 standards or later.</u>

Note: *For organizations that have both NCQA-Accredited and non-Accredited delegates:*

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Factor 1: **Review of the UM program**

The appropriate organization staff or committee review the delegate's UM program. At a minimum, the organization reviews parts of the UM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates the denial and appeal processes, it audits denial and appeal files against NCQA standards.

The organization uses one of the following to audit the delegate's files:

- 5% or 50 of its files, whichever is less, *or*
- The NCQA "8/30 methodology," available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupporting Documents.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

For mail service delegates only, the organization may submit the delegate's timeliness report of mail distribution in lieu of an audit.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

<u>Factor 5:</u> **<u>Annual audit UM information integrity</u>**

<u>If the organization delegates processing of UM requests covered in UM 4–UM 7, or UM appeal requests covered in UM 8–UM 9, the organization or the delegate annually audits (as applicable) the delegate's UM denial and appeal files separately for inappropriate documentation and inappropriate updates to:</u>

- <u>UM request receipt dates (UM 5).</u>

- UM denial decision notification dates (UM 5, UM 7).
- UM appeal request receipt dates (UM 8, UM 9).
- UM appeal decision notification dates (UM 8, UM 9).

For each delegate, the audit universe includes UM denial and appeal files processed by the delegate during the look-back period. Denial and appeal files are audited separately.

Because an organization may have several UM delegates processing UM requests and appeals, the organization annually audits each delegate using one of the following methods:

- 5% or 50 files, whichever is less, *or*
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/ policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

The organization or delegate may choose to audit more UM denial and appeal files than NCQA specifies.

The organization provides an auditing and analysis report that includes:

- The date of the report.
- Title of staff who conducted the audit.
- The audit method:
  - Audit period.
  - Audit universe size.
  - Audit sample size.
- File identifier (case number).
- Type of dates audited (receipt date, notification date).
- Findings for each file.
  - Draw a conclusion if inappropriate documentation and updates occur.
- The number or percentage and total inappropriate documentation and updates by date type.

The delegate or organization must provide a completed audit report even if no inappropriate findings were found.

If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.

Factor 6: **Implement corrective actions**

For each delegate with inappropriate documentation and updates (findings) identified in factor 5, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified in factor 5. One action may be used to address more than one finding, if appropriate.

The organization's corrective action plan identifies staff (by title who are responsible for implementing corrective actions.

Factor 7: **Measure effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 6) on findings for each delegate within 3–6 months of the annual audit completed for factor 5.

For each delegate, the audit universe includes 3–6 months of UM denial and appeal files processed by the delegate since the annual audit. Denial and appeal files are audited separately.

The organization or delegate conducts an qualitative analysis if it identifies integrity during the follow-up audit.

If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate findings.

The organization draws conclusions on the actions' overall effectiveness.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 1 is NA for mail service delegates.

Factors 2–7 are NA for Interim Surveys.

Factors 3 and 4 are NA if a mail service delegate distributes information for an element with an annual frequency.

Factors 5-7 are NA if the delegate only provides cloud-based UM data storage functions and does not provide services that create, modify or use UM data.

Factors 5–7 are NA for mail service delegates that:

- Do not have access to the organization's UM system.
- Do not have a UM system of their own.
- Do not modify or store the UM data sent by the organization.

Factors 6 and 7are NA if the organization's audit of all delegates' denial and appeal files did not identify any inappropriate documentation or updates to receipt dates and decision notification dates. This must be evident in reports reviewed for factor 5.

Factor 7 is NA if the timing of the organization's annual audit is less than three months before the organization's NCQA survey.

Related information

Use of collaborative. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool, and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples   *Excerpt of an audit and analysis report*

Factor 5: **Annual audit**

Each January, the delegate's UM director audits for inappropriate documentation and updates to UM 8–UM 9:

- UM appeal request receipt dates.
- UM appeal decision notification dates.

The delegate randomly samples and audits 5% or 50 files (whichever is less) of all UM appeal decisions made in the previous year.

Identify the universe. The delegate made 1,500 UM appeal decisions regarding coverage in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 1,500 UM appeal files.

Calculate the sample size. Multiply the total number of UM appeal files in the universe by 5% (1,500 files x 0.05 = 75 files).

Randomly select the files for the sample, for a total of 50 files.

Audit the selected file sample. Audit the files for inappropriate documentation and updates, and document findings.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	0	0	0%

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1235	No	None	NA
1245	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 2:59 PM

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1255	No	NA	NA

Case ID	Inappropriate Documentation/ Updates?	Date Affected	Finding
1265	No	NA	NA
1275	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. 3/3/XX @ 3:40 PM
1285	Yes	Receipt Notification	Receipt and notification dates updated by staff (name) because urgent concurrent decision time frame had passed. on 3/3/XX @ 4:00 PM

Factor 5: **Audit report and analysis**

Methodology

- Delegate: [Delegate].
- Frequency: Annual (January).
- Audit sample: Sample UM denial files using NCQA "5% or 50 files" method.
- Universe: All UM appeal files from January–December of the previous year.
- Auditor: UM director.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	35	15	30%
UM appeal decision notification date	35	15	30%
Total	35	15	30%

Qualitative analysis. The delegate's UM analyst provided the UM director with the audit log documenting when, how, why and by whom files were updated.

The UM director met with UM staff (UM assistant director, UM manager, UM analyst) to determine the cause inappropriate documentation and updates to UM appeal receipt and notification dates.

Date Type	Description of Noncompliant Update	Reason
UM appeal request receipt date	All 15 receipt dates were improperly updated in the UM appeal file by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the expedited appeal decision time frame had passed and an audit by the

Date Type	Description of Noncompliant Update	Reason
		Department of Insurance was scheduled for 5/10/XX.
		Staff felt pressure from leadership to pass the state audit at any cost.
UM appeal decision notification date	All 15 notification dates were improperly updated by the same staff on 5/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the appeal decision notification time frame had passed and an audit by the Department of Insurance was scheduled for 5/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.

Excerpt from reports of corrective actions and measures of effectiveness

Factor 6: **Corrective actions**

The organization required the delegate to implement immediate corrective actions to address information integrity issues after sharing audit and analysis results with UM staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

UM Information/ Noncompliant Update	Reason	Actions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Receipt dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Require delegate's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date] Require delegate to update UM system to read only records for dates and other UM information. [Date].
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Decision notification dates were improperly updated because the urgent concurrent decision time frame had passed and an audit by the Department of Insurance was scheduled for 3/10/XX. Staff felt pressure from leadership to pass the state audit at any cost.	Require delegate to establish process for two-step verification of system dates to records/information prepared for external review bodies.

Factor 7: **Effectiveness of corrective actions audit**

The delegate audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology

- *Audit staff:* Names, titles.
- Frequency: Annual (January).
- Audit sample: Sample UM appeal files using NCQA "5% or 50 files" method.
- Universe: All UM appeals files from January–December of the previous year.

Sample calculation

- File universe = 1,500 files.
- 5% or 50 files calculation = 1,500 x .05 = 75 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 50 UM denial files.

Date Type	Compliant Denial Files	Noncompliant Denial Files	Percentage of Noncompliant Denial Files
UM appeal request receipt date	50	0	0%
UM appeal decision notification date	50	0	0%
Total	0	0	0%

Conclusions on the actions' overall effectiveness

UM Information/ Noncompliant Update	Actions	Conclusions
UM appeal request receipt dates: UM staff member improperly updated request receipt dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Delegate's leadership and UM staff to undergo ethics training, with emphasis on following UM information integrity policies and procedures. [Date]	Delegate's leadership and UM staff to completed ethics training on [Date] and UM Information integrity training on [Date]
UM appeal decision notification dates: UM staff member improperly updated decision notification dates in 15 UM denial file on 3/3/XX, after a decision had been sent.	Delegate to update UM system to read only records for dates and other UM information. [Date].	Delegate updated its UM system to read only records on [Date].
	Delegate to establish process for two-step verification of system dates to records/information prepared for external review bodies.	Delegate implemented two-step verification process on [Date] and ran a test real-world scenario for information purposes [Date]

The correction implemented has been effective overall; the audit did not find incidents of inappropriate documentation and update.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source   Documented process, Reports, Materials

Scope of review

Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First Surveys and Renewal Surveys: NCQA reviews reports for opportunities for improvement from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation   This element may not be delegated.

This element does not apply to UM information integrity requirements, which are addressed in Element C, factors 5–7.

NCQA-Accredited delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in UM, unless the element is NA.

Note: For organizations that have both NCQA-Accredited and non-Accredited delegates:

- *NCQA-Accredited delegates are eligible for automatic credit.*
- *Non-Accredited delegates are reviewed and scored accordingly.*

Identify and follow-up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate UM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples   None.

Credentialing

CR 1: Credentialing Policies

The organization has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.

Intent

The organization has a rigorous process to select and evaluate practitioners.

Element A: Practitioner Credentialing Guidelines

The organization specifies:

1.   **The types of practitioners it credentials and recredentials.**

2.   **The verification sources it uses.**

3.   **The criteria for credentialing and recredentialing.**

4.   **The process for making credentialing and recredentialing decisions.**

5.   **The process for managing credentialing files that meet <u>and do not meet</u> the organization's established criteria.**

6.   **<u>The criteria for practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing committee.</u>**

<u>7.</u>~~6.~~   The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.

<u>8.</u>~~7.~~   The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization.

<u>9.</u>~~8.~~   The process for notifying practitioners of the credentialing and recredentialing decision within <u>30</u> ~~60~~ calendar days of the credentialing committee's decision.

<u>10.</u>~~9.~~   The medical director or other designated physician's direct responsibility and participation in the credentialing program.

<u>11.</u>~~10.~~ The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.

<u>12.</u>~~11.~~ The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification and specialty.

<u>13.</u>   <u>The process for documenting information and activities in credentialing files.</u>

	Met	Partially Met	Not Met
Scoring	The organization meets ~~9-13~~<u>11</u> factors	The organization meets ~~5-8~~<u>-12</u> factors	The organization meets 0-4<u>7</u> factors

Data source   Documented process

Scope of review	**Product lines**

For Interim Surveys and First Surveys, this element applies to all product lines.

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's policies and procedures in effect throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This element is a **structural requirement**. The organization must present its own documentation.

Practitioners within the scope of credentialing

Practitioners are within the scope of credentialing if all criteria listed below are met:

- Practitioners are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners have an independent relationship with the organization.
  – An independent relationship exists when the organization directs members to see a specific practitioner or group of practitioners, including all practitioners members can select as primary care practitioners.
  – <u>Please note, organizations that utilize locum tenens are required to include those practitioners in the scope of credentialing.</u>
- Practitioners provide care to members under the organization's medical benefits.

The listed criteria apply to practitioners in the following settings:

- Individual or group practices.
- Facilities.
- Telemedicine.
- Rental networks:
  – That are part of the organization's primary network and the organization has members who reside in the rental network area.
  – Specifically for out-of-area care and members may see only those practitioners or are given an incentive to see rental network practitioners.
- PPO network:
  – If an organization contracts with a PPO network to provide health services to members who need care outside its service area, and if it encourages members to obtain care from that network when they are outside the network, NCQA considers this to be an independent relationship if:
    ▪ Information about the network is included in member materials or on an ID card that directs members to the network (e.g., network name, phone number, logo), or
    ▪ There are incentives for members to see the PPO's practitioners.

In this type of contractual arrangement, the organization must credential the practitioners or delegate credentialing to the PPO network.

Factor 1: **Types of practitioners**

Credentialing policies and procedures include the following types of practitioners.

- *Medical practitioners:*
  - Medical doctors.
  - Oral surgeons.
  - Chiropractors.
  - Osteopaths.
  - Podiatrists.
  - Nurse practitioners.
  - Other medical practitioners who may be within the scope of credentialing (e.g., certified nurse midwife).
    - NCQA does not include these practitioners in the credentialing file review.
- *Behavioral healthcare practitioners:*
  - Psychiatrists and other physicians.
  - Addiction medicine specialists.
  - Doctoral or master's-level psychologists.
  - Master's-level clinical social workers.
  - Master's-level clinical nurse specialists or psychiatric nurse practitioners.
  - Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselor).

Factor 2: **Verification sources**

Credentialing policies and procedures describe the sources the organization uses to verify credentialing information. The organization uses any of the following sources to verify credentials:

- The primary source (or its website).
- ~~A contracted agent of the primary source (or its website).~~
  - ~~The organization obtains documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.~~
- An NCQA-accepted source listed for the credential (or its website).

Factors 3, 4: **Decision-making criteria and process**

The organization:

- Credentials practitioners before they provide care to members.
- Has a process for making credentialing decisions, and defines the criteria it requires to reach a credentialing decision.
  - Criteria are designed to assess a practitioner's ability to deliver care.
  - <u>Criteria are reviewed and approved by the medical director or the Credentialing Committee.</u>
- <u>Makes a final determination regarding</u> ~~Determines~~ <u>which practitioners may participate in its network based on specified criteria.</u>

Factor 5: **Managing files that meet <u>and do not meet</u> criteria**

Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files) <u>and files that do not meet the criteria</u>. The organization may present all practitioner files to the Credentialing

Committee or may designate approval authority of clean files to the medical director or to an equally qualified practitioner.

Factor 6: Criteria for ongoing monitoring notifications to the credentialing committee

Credentialing policies and procedures outline the criteria the organization uses to determine the types of practitioner sanctions, complaints and other adverse events found during ongoing monitoring that need to be reviewed by the credentialing committee.

Factor 7~~6~~: Nondiscriminatory credentialing and recredentialing

Credentialing policies and procedures:
- State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes.
- Specify the process for preventing discriminatory practices.
  – Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes.
  – Considers the demographic makeup of the credentialing committee to the demographic makeup of the patient population.
- Specify how the organization monitors the credentialing and recredentialing processes for discriminatory practices, at least annually.
  – Monitoring involves tracking and identifying discrimination in credentialing and recredentialing processes.

Factor 8~~7~~: Discrepancies in credentialing information

Credentialing policies and procedures describe the organization's process for notifying practitioners when credentialing information obtained from other sources varies substantially from that provided by the practitioner in their credentialing application.

Factor 9~~8~~: Notification of decisions

Credentialing policies and procedures specify that the organization's time frame for notifying applicants of initial credentialing decisions and recredentialing denials does not exceed 30 ~~60~~ calendar days from the Credentialing Committee's decision. The organization is not required to notify practitioners regarding recredentialing approvals.

Factor 10~~9~~: Participation of a medical director or designated physician

Credentialing policies and procedures describe the medical director or other designated physician's overall responsibility and participation in the credentialing process.

Factor 11~~10~~: Ensuring confidentiality

Credentialing policies and procedures describe the organization's process for ensuring confidentiality of the information collected during the credentialing process and the procedures it uses to keep this information confidential.

Factor 12~~11~~: **Practitioner directories and member materials**

Credentialing policies and procedures describe the organization's process for ensuring that information provided in member materials and practitioner directories is consistent with the information obtained during the credentialing process.

Factor 13: **Appropriate documentation**

Credentialing policies and procedures define the organization's process for documenting information and activities in credentialing files. The organization documents verification in the credentialing files using any of the following methods, or a combination:

- Credentialing documents signed (or initialed) and dated by the verifier.
- A checklist that includes for each verification:
  - The source used.
  - The date of verification.
  - The signature or initials of the person who verified the information.
    - Typed initials are only acceptable if there is a unique electronic signature or identifier on the checklist.
  - The report date, if applicable.
- A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification:
  - The source used.
  - The report date, if applicable.

Exception

This element is NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

Related information

Appropriate documentation. ~~Credentialing policies and procedures define the organization's process for documenting information and activities in credentialing files. The organization documents verification in the credentialing files using either of the following methods or a combination:~~

- ~~Credentialing documents signed (or initialed) and dated by the verifier.~~
- ~~A checklist that includes, for each verification:~~
  - ~~The source used.~~
  - ~~The date of verification.~~
  - ~~The signature or initials of the person who verified the information.~~
    - ~~Typed initials are only acceptable if there is a unique electronic signature or identifier on the checklist.~~
  - ~~The report date, if applicable.~~
- ~~A checklist with a single signature and a date for all verifications that has a statement confirming the signatory verified all of the credentials on that date and that includes for each verification:~~
  - ~~The source used.~~
  - ~~The report date, if applicable.~~

Verification from a report. NCQA uses the date generated by the source when the information is retrieved. ~~If the source report does not generate a date, NCQA uses the date noted in the credentialing file by the organization staff who verified the credentials.~~ Staff who verified the credentials must sign or initial the verification.

Automated credentialing system. The organization may use an electronic signature or unique electronic identifier of staff to document verification if it can demonstrate that the electronic signature or unique identifier can only be entered by the signatory. The organization provides its security and login policies and procedures to confirm the unique identifier and that the signature can only be entered by the signatory. The system must identify the individual verifying the information, the date of verification, the source and the report date, if applicable.

- Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable.
- If the checklist does not include checklist requirements listed above, appropriate credentialing information must be included.

Use of software for data collection. NCQA does not consider it delegation if the organization uses another entity's software to collect credentialing information, unless the entity also reviews the credentialing information on behalf of the organization.

Use of web crawlers. The organization may use web crawlers to verify credentialing information from approved sources. A "web crawler" is software that retrieves information directly from a primary or approved source website (e.g., the state licensing or certification agency). The organization provides documentation that the web crawler collects information only from approved sources, and documents that staff reviewed the credentialing information.

Provisional credentialing. If the organization decides to provisionally credential practitioners, it:

- Has a process for one-time provisional credentialing of practitioners applying to its network for the first time.
- Verifies the following within the required time limits:
  - A current, valid license to practice (CR 3, Element A~~, factor 1~~).
  - The past 5 years of malpractice claims or settlements from the malpractice carrier, or the results of the National Practitioner Data Bank (NPDB) query (CR 3, Element F~~A, factor 6~~).
  - A current and signed application with attestation (CR 3, Element I~~C, factors 1–6)~~.
- Follows the same process for presenting provisional credentialing files to the Credentialing Committee or medical director as it does for its regular credentialing process.
- Does not perform provisional credentialing for practitioners who were credentialed by a delegate on behalf of the organization.
- Does not hold practitioners in provisional status for longer than 60 calendar days.
- Does not list provisionally credentialed practitioners in the directory.
- Does not allow practitioners to deliver care prior to completion of provisional credentialing.

Practitioners who do not need to be credentialed.

- Practitioners who practice exclusively in an inpatient setting and provide care for organization members only because members are directed to the hospital or another inpatient setting.
- Practitioners who practice exclusively in free-standing facilities and provide care for organization members only because members are directed to the facility.
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions.
- ~~Covering practitioners (e.g., locum tenens).~~
- ~~Locum tenens who do not have an independent relationship with the organization are outside NCQA's scope of credentialing.~~
- Practitioners who do not provide care for members (e.g., board-certified consultants who may provide a professional opinion to the treating practitioner).
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Practitioner termination and reinstatement. The organization:

- Initially credentials a practitioner again if the break in network participation is more than 30 calendar days.
  - The organization re-verifies credentials that are no longer within verification time limits.
  - The organization re-verifies credentials that will not be in effect when the Credentialing Committee or medical director makes the credentialing decision.

Examples *Factor 76:* **Nondiscriminatory credentialing and recredentialing**

The organization monitors credentialing decisions to prevent discrimination. Monitoring includes, but is not limited to:

- Maintaining a heterogeneous credentialing committee membership and the requirement for those responsible for credentialing decisions to sign a statement affirming that they do not discriminate.
- Periodic audits of credentialing files (in-process, denied and approved files) that suggest potential discriminatory practice in selecting practitioners.
- Annual audits of practitioner complaints for evidence of alleged discrimination.

Electronic signature software applications

- Adobe Sign.
- DocuSign.

Element B: Practitioner Rights

The organization notifies practitioners about their right to:

1. Review information submitted to support their credentialing application.

2. Correct erroneous information.

3. Receive the status of their credentialing or recredentialing application, upon request.

	Met	Partially Met	Not Met
Scoring	The organization meets 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Materials

Scope of review

Product lines

For Interim Surveys and First Surveys, this element applies to all product lines.

For Renewal Surveys, this element applies to the Medicaid product line only.

Documentation

NCQA reviews the organization's policies and procedures for all three factors.

For First Surveys and Renewal Surveys: NCQA also reviews three materials sent to practitioners throughout the look-back period, or reviews all materials if the organization has fewer than three.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   This element is a **structural requirement**. The organization must present its own documentation.

Factor 1: **Review information**

The organization notifies practitioners of their right to review information obtained from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support their credentialing application. The organization is not required to make available:

- References.
- Recommendations.
- Peer-review protected information.

Factor 2: **Correct erroneous information from other sources**

The organization notifies practitioners of their right to correct erroneous information and:

- The time frame for making corrections.
- The format for submitting corrections.
- Where to submit corrections.

The organization is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.

The organization documents receipt of corrected information in the practitioner's credentialing file.

Factor 3: **Application status**

- The organization notifies practitioners of:
- Their right to be informed of the status of their application, upon request.
- The information it is allowed to share with practitioners.
- Its process for responding to requests for application status.

Exception

This element is NA for Renewal Surveys for the commercial, Medicare and Exchange product lines.

Examples	**Avenues for notification**

- Application.
- Contract.
- Provider manual.
- Other information distributed to practitioners.
- Website.
- Letter to practitioners.

Factor 2: **Areas where variation from information provided may occur**

- Actions on a license.
- Malpractice claims history.
- Board certification.

Element C: Credentialing System Controls

The organization's credentialing process describes:

1. **How primary source verification information is received, dated and stored.**

2. **How modified information is tracked and dated from its initial verification.**

3. **Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate.**

4. **The security controls in place to protect the information from unauthorized modification.**

5. **How the organization monitors its compliance with the policies and procedures in factors 1–4 at least annually and takes appropriate action when applicable.**

	Met	Partially Met	Not Met
Scoring	The organization meets 5 factors	No scoring option	The organization meets 0-4 factors

Data source   Documented process

Scope of review — **Product lines**

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for its credentialing system security controls.

Factor 1 applies to verification source information from credentialing and recredentialing cycles, covered in CR 3, Elements A–C.

Factor 2 applies to modified credentialing verification information from initial credentialing and recredentialing cycles, covered in CR 3, Elements A–C.

Factors 3, 4 apply to all information associated with credentialing/recredentialing of practitioners, covered in CR 2–CR 5.

Factor 5 requires a monitoring process that covers compliance with all policies and procedures described in factors 1–4.

The organization must have policies and procedures for all factors regardless of system functionality.

Look-back period — *For Interim Surveys:* Prior to the survey date.

For First Surveys: 6 months for factors 1–4; prior to the survey date for factor 5.

For Renewal Surveys: 24 months for factors 1–4; prior to the survey date for factor 5.

Explanation — **THIS IS A MUST-PASS ELEMENT.**

This element is a **structural requirement.** The organization must present its own documentation.

This element applies to both paper and electronic credentialing processes.

Refer to *Appendix 4: Glossary* for the definition of "modification." The organization determines when modification is appropriate. See *Examples* of modifications below.

Factor 1: **Primary source verification information**

The organization's policies and procedures describe how credentialing information is received, stored, reviewed, tracked and dated.

Factor 2: **Tracking modifications**

The organization's policies and procedures describe how it tracks modifications made to credentialing information, and include, at a minimum:

- When the information was modified.
- How the information was modified.
- Staff who modified the information.
- Why the information was modified.

Factor 3: **Authorization to modify information**

The organization's policies and procedures identify:

- All staff titles or roles authorized to access, modify and delete information.

~~Policies and procedures state if no staff are authorized to modify dates under any circumstances.~~

- ~~Circumstances when modification or deletion of information is appropriate.~~

Factor 4: Securing information

~~The organization's policies and procedures describe the process for:~~

- ~~Limiting physical access to the operating environment that houses credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.~~
  - ~~Physical access may include, but is not limited to, the organization's computer servers, hardware and physical records and files.~~
  - ~~"Physical access" does not refer to the organization's building or office location.~~
- ~~Preventing unauthorized access, changes to and release of credentialing information. See *Examples* below.~~
- ~~Password-protecting electronic systems, including user requirements to:~~
  - ~~Use strong passwords.~~
  - ~~Discourage staff from writing down passwords.~~
  - ~~Use IDs and passwords unique to each user.~~
  - ~~Change passwords when requested by staff or if passwords are compromised.~~

  ~~*Note: If the organization's policies and procedures state that it follows the National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems.*~~

- ~~Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.~~

Factor 5: Annually monitoring the credentialing process

~~The policies and procedures describe the organization's process for at least annually:~~

- ~~Monitoring compliance with policies and procedures for factors 1–4.~~
- ~~Analyzing modifications that do not meet the organization's established policy and taking actions, when applicable.~~

~~The description includes:~~

- ~~The method used to monitor compliance with the organization's policies and procedures described in factors 1–4.~~
  - ~~If the organization conducts auditing as the method for monitoring:~~
    - ~~All noncompliant modifications must be reviewed if the organization's system can identify noncompliant modifications.~~
    - ~~Sampling is allowed only if the organization does not use a credentialing system that can identify all noncompliant modifications. Refer to the *Related information* for details on the sampling methodology.~~
- ~~The staff titles or roles responsible for oversight of the monitoring process.~~
- ~~The organization's process for taking actions if it identifies modifications that do not meet its established policy, including:~~
  - ~~A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.~~

~~The staff roles or department responsible for the actions.~~

~~The process for documenting and reporting modifications that do not meet its established policy.~~

~~The organization's policies and procedures must include a description of the monitoring process outlined above, regardless of system functionality (e.g., the system prevents changes to the original record under any circumstances, but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify noncompliance), with the exception of advanced system controls capabilities.~~

~~*Advanced system controls capabilities.* An advanced system must have both capabilities:~~

- ~~Automatically record dates, **and**~~

- ~~Prevent changes that do not meet the organization's policies and procedures. If the organization has advanced system controls capabilities, it is only required to describe how the functionality of the system ensures compliance with established policies in factors 1–4. Monitoring is not required.~~

~~**Exceptions**~~

~~None.~~

~~**Related Information**~~

~~*Factor 5: Sampling methodology for auditing.* Sampling is allowed for organizations that use auditing as the monitoring method in Elements C and D.~~

~~The organization must use the "5% or 50 files" audit method: Randomly select 5% of files or 50 files (whichever is less) from each applicable file type, to review against requirements.~~

~~At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.~~

~~The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the organization's policies and procedures).~~

~~Once the sample size is calculated from the entire file universe, the organization determines how it selects the sample. NCQA does not specify how the organization selects the sample once the sample size is determined using the entire file universe.~~

~~If the organization:~~

- ~~*Can identify files with modifications,* it may randomly select a sample from a universe that contains modified files.~~

- ~~*Cannot identify files with modifications,* it may randomly select a sample from the entire file universe; the organization continues to pull files from the entire universe until 5% or 50 files in the sample have modifications.~~

Examples ~~***Examples of modifications*** *(see Appendix 4: Glossary for the definition of modification)*~~

- ~~Correcting typographical errors.~~

- ~~Deleting information.~~

- Changing practitioner information.
- Creating a new record in place of an existing record.

Factor 4: Preventing unauthorized access and changes to data

Preventing unauthorized access and changes may include:

- Limiting login attempts.
- Multifactor authentication.
- IP address authentication/matching.
- Use of firewalls.
- Use of antivirus software or spyware protection programs.
- Assigning user rights and leveling (permission tiers).

***Factor 5:* Annually monitoring the credentialing process**

The organization's policies and procedures describe its process for monitoring compliance with policies and procedures for factors 1–4.

Methods of monitoring activities may include:

- An annual process for identifying modifications that did not meet policies and procedures in the past 12 months and taking actions to update credentialing system controls accordingly.
- A review of automatic system alerts or flags for modifications or events in real time, and a separate process for annually testing performance of the system's automatic alerts or flags and taking actions to update credentialing system controls accordingly.
- A monthly, quarterly or semiannual process to audit files from a system-generated report of all date modifications to identify modifications that did not meet policies and procedures and take actions to update credentialing system controls accordingly.

***Factor 5:* Audit sampling**

An organization's credentialing and recredentialing file universe contains 800 files (with and without modifications). The minimum required sample for review is 40 files (5% of 800), which is less than 50 files. The organization randomly selects the 40 files for review from the total universe of 800 files, or from only files with modifications (if the organization's system can identify files with modifications). All 40 files must have a modification and the organization reviews the files against its policies and procedures to identify noncompliant modifications.

Element D: Credentialing System Controls Oversight

At least annually, the organization demonstrates that it monitors compliance with its credentialing controls, as described in Element C, factor 5, by:

1. **Identifying all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures for modifications.**

2. **Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications.**

3. **Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.**

~~Scoring~~	~~Met~~	~~Partially Met~~	~~Not Met~~
	~~The organization meets 3 factors~~	~~No scoring option~~	~~The organization meets 0-2 factors~~

~~**Data source**~~ ~~Reports~~

~~**Scope of review**~~ ~~**Product lines**~~

~~*This element applies to all product lines for First Surveys and Renewal Surveys.*~~

~~**Documentation**~~

~~*For First and Renewal Surveys:* NCQA reviews the organization's analysis report, and reviews evidence that the organization identified, analyzed and acted only on modifications to credentialing/recredentialing information (CR 2–CR 5) that did not meet its policies and procedures.~~

~~This element is scored Met if the organization provides evidence, in lieu of monitoring and analysis reports, of advanced system control capabilities that automatically record dates and prevent changes that do not meet the organization's policies and procedures for modifications; the system must have both capabilities. *See Examples* below.~~

~~**Look-back period**~~ ~~*For All Surveys:* Prior to the survey date.~~

~~**Explanation**~~ ~~This element is a **structural requirement.** The organization must present its own documentation.~~

~~This element applies to both paper and electronic credentialing processes.~~

~~*Factor 1:* **Identifying all modifications that did not meet the policies and procedures**~~

~~The organization demonstrates that at least annually, it identifies all modifications to credentialing and recredentialing information that did not meet the organization's policies and procedures outlined in CR 1, Element C.~~

~~*Factor 2:* **Analyzing all modifications that did not meet the policies and procedures**~~

~~The organization demonstrates that at least annually, it conducts quantitative and qualitative analysis of all modifications that did not meet its policies and procedures outlined in CR 1, Element C.~~

~~A goal is not required for the quantitative analysis. The organization reviews all instances of modifications that did not meet its policies and procedures.~~

~~*Note: If the organization uses sampling, it reviews all noncompliant modifications in the sample.*~~

~~The organization's analysis report includes the number or percentage of noncompliant files.~~

~~Refer to *Appendix 4: Glossary* for the full definitions of and requirements for quantitative analysis and qualitative analysis.~~

~~*Factor 3:* **Acting on all findings**~~

~~The organization identifies and documents all actions it has taken, or plans to take, to address all modifications (factors 1 and 2) that did not meet its policies and~~

~~procedures, if applicable. One action may be used to address more than one finding, if appropriate.~~

~~The organization also implements a quarterly monitoring process to assess the effectiveness of its actions on all findings.~~

- ~~The organization must continue to monitor until it demonstrates improvement of at least one finding over three consecutive quarters.~~
- ~~If the organization did not demonstrate improvement of at least one finding during the look-back period, it submits all quarterly monitoring reports demonstrating ongoing monitoring.~~
- ~~If the organization identified findings less than three quarters before the survey submission date, it submits all monitoring information it has available.~~

~~Exception~~

~~Factors 2 and 3 are NA if:~~

- ~~The organization did not identify any modifications that do not meet the organization's policies and procedures, **or**~~
- ~~All identified modifications met the organization's policies and procedures.~~

~~Related information~~

~~Although NCQA requires an overall monitoring process in Element C, factor 5, that covers compliance with policies and procedures from factors 1–4, NCQA only reviews evidence in Element D that the organization monitored modifications that did not meet its policies and procedures.~~

~~Examples~~   **~~Examples of evidence for demonstrating advanced system capabilities~~**

~~Evidence includes, but is not limited to:~~

- ~~A system manual with functionality specifications.~~
- ~~A screenshot of system functionality that includes a description.~~
- ~~A screenshot with a separate description of system functionality.~~

CR 2: Credentialing Committee

The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions.

Intent

The organization obtains meaningful advice and expertise from participating practitioners when it makes credentialing decisions.

Element A: Credentialing Committee

The organization's Credentialing Committee:

1. **Uses participating practitioners to provide advice and expertise for credentialing decisions.**

2. **Reviews credentials for practitioners who do not meet established thresholds.**

3. **Ensures that files that meet established criteria are reviewed and approved by a medical director, designated physician or the Credentialing Committee.**

4. **Reviews sanctions, complaints and other adverse events found during ongoing monitoring based on the organization's criteria in CR 1, Element A and makes recommendations about actions.**

Scoring

Met	Partially Met	Not Met
The organization meets 3-4 2-3 factors	No scoring option	The organization meets 0-1 factors

Data source   Documented process, Reports

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

For Interim Surveys: NCQA reviews Credentialing Committee minutes from three different meetings, or reviews the Credentialing Committee charter, and reviews a timeline for operationalizing the committee, if the committee has not met. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available within the look-back period.

For First Surveys and Renewal Surveys: NCQA reviews Credentialing Committee meeting minutes from three different meetings within the look-back period. If the required meeting minutes are not available for review, NCQA reviews the meeting minutes that are available from within the look-back period.

NCQA also reviews the organization's list of practitioners who had sanctions, complaints, and other adverse events during ongoing monitoring (CR5, Element A, factors 1 and 2), and Credentialing Committee meeting minutes for recommendations on the listed practitioners at the next Committee meeting after the identified occurrence.

Look-back period	*For Interim Surveys:* Prior to the survey date.
	For First Surveys: 6 months~~.~~,prior to survey for factor 4.
	For Renewal Surveys: 24 months.
Explanation	*Factor 1:* **Participating practitioners**

Factor 1: **Participating practitioners**

The Credentialing Committee is a peer-review body with members from the types of practitioners participating in the organization's network.

The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties.

If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization.

Note: *Participating practitioners are external to the organization and are part of the organization's network.*

Factor 2: **Committee review**

The Credentialing Committee:

- Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network.
- Gives thoughtful consideration to credentialing information.
- Documents discussions about credentialing in meeting minutes.

Meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or web conference with audio), but may not be conducted only through email.

Factor 3: **Review of files that meet established thresholds**

For files that meet the organization's credentialing criteria, the organization:

- Submits all practitioner files to the Credentialing Committee for review, *or*
- Has a process for medical director or qualified physician review and approve clean files.
  - Evidence of review and approval is a handwritten signature, handwritten initials or unique electronic identifier, if the organization has appropriate controls for ensuring that only the designated medical director or qualified physician can enter the electronic signature.
  - An individual signature is not required in each practitioner file if there is one report with a signature that lists all required credentials for all practitioners with clean files.
  - Clean files that meet the organization's established criteria may be reviewed by email.

NCQA scores this factor "yes" if the organization presents all files (including clean files) to the Credentialing Committee.

Factor 4: **Review of sanctions, complaints, or other adverse events**

During on-going monitoring, the committee meets and reviews practitioners sanctions, complaints or other adverse events to determine action following the information found. The committee documents its findings and subsequent actions in between recredentialing cycles.

Exceptions

None.

Related information

Assessment of timeliness. NCQA considers a practitioner to be credentialed as of the Credentialing Committee or medical director decision date, and uses this date to assess timeliness in the file review elements, even if a review board or governing body reviews decisions made by the Credentialing Committee or medical director.

Providing care to members. The organization does not permit uncredentialed practitioners to provide care to members.

Some states require reimbursement of practitioners back to the date the application, for members seen during the credentialing process period, if the organization subsequently decides to credential the practitioner. Such retro-payment is outside the scope of NCQA's credentialing requirement.

Examples   None.

CR 3: Credentialing Verification

The organization verifies credentialing information through primary sources, unless otherwise indicated.

<div style="background:black;color:white;padding:4px">Intent</div>

The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care.

<div style="background:black;color:white;padding:4px">Element A: Verification of Licensure</div>

The organization verifies that practitioners have a current and valid license to practice within <u>90 calendar days at the time of the credentialing decision.</u>

	Met	Partially Met	Not Met
Scoring	<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.
- For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, <u>factor 13.</u> *~~Related information,~~* ~~"Appropriate documentation."~~

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ <u>90</u> calendar days.

The organization verifies that the practitioner has a valid and current license to practice at the time of the credentialing decision. The organization verifies license

in all states where the practitioner provides care to members. The organization must verify license directly from state licensing or certification agency or its website.

Element B: Verification of DEA or CDS

The organization verifies that practitioners have a valid DEA or CDS, if applicable:

Scoring	Met	Partially Met	Not Met
	To be determined	To be determined	To be determined

Data source Records or files

Scope of review NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

For All Surveys: For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS-eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2022 standards or the applicable prior year's standards, which state, "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."

Explanation **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, <u>factor 13.</u> *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: Prior to the credentialing decision.

This factor applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA)

or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Acceptable verification sources:

- DEA or CDS agency.
- DEA or CDS certificate, or a photocopy of the certificate.
- Documented visual inspection of the original DEA or CDS certificate.
- Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).
- American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only).
- Confirmation from the state pharmaceutical licensing agency, where applicable.

Pending DEA certificates. The organization may credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate.

DEA- and CDS-eligible practitioners who do not have certificates. The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber.

If the practitioner states in writing that they do not prescribe controlled substances and that in their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.

Element C: Verification of Education and Training

The organization verifies that practitioner's education and training.

Scoring	Met	Partially Met	Not Met
	To be determined	To be determined	To be determined

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, <u>factor 13.</u> *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: Prior to the credentialing decision.

The organization verifies the highest of the following three levels of education, and training obtained by the practitioner as appropriate:

1. Board certification.
2. Residency.
3. Graduation from medical or professional school.

<u>Additionally, the organization verifies fellowship, if applicable.</u>

The organization uses any of the following to verify education and training:

- The primary source.
- The state licensing agency, specialty board or registry, if it performs primary source verification.
  - The organization:
    - Obtains written confirmation at least annually from the state licensing agency, specialty licensing agency, specialty board or registry that primary source verifies education and training information, *or*
    - Provides a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information, *or*
    - Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.
- Sealed transcripts, if the organization provides evidence that it inspected the contents of the envelope and confirmed that the practitioner completed (graduated from) the appropriate training program.

Verification of fellowship does not meet the intent of this factor.

Future dates of program completion do not meet the intent of this factor.

Other acceptable verification sources for physicians (MD, DO)

Board certification

- For physicians (MD, DO):
  - ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.
    Note: *The ABMS "Is Your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.*
  - AMA Physician Masterfile.
  - AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
  - Boards in the United States that are not members of the ABMS or AOA (e.g., NBPAS), if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.
- For other health care professionals:
  - Registry that performs primary source verification of board status if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.

Expired board certification meets requirements because primary-source verified education and training information would not change with expiration of board certification.

Graduation from medical school

- AMA Physician Masterfile.
- American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.
- Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.

Completion of residency training

- AMA Physician Masterfile.
- AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.
- FCVS for closed residency programs.

NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Council for Graduate Medical Education—International, the American Osteopathic Association (in the United States), the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.

Element D: Verification of Board Certification Status

The organization verifies practitioners board certification status <u>within 90 calendar days at the time of the credentialing decision,</u> if applicable.

Scoring	Met	Partially Met	Not Met
	<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, <u>factor 13.</u> *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ <u>90</u> calendar days.

NCQA does not require board certification; however, the organization verifies current certification status of practitioners who state that they are board certified.

The organization documents the expiration date of the board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. If the expiration date is not provided, the organization may leave the expiration date blank in the practitioner file.

Verification sources.

The organization uses any of the following to verify board certification:

- For all practitioner types:

> – The primary source (appropriate specialty board).
> – The state licensing agency if it primary source verifies board certification.
- For physicians (MD, DO), the sources listed under Element C ~~Factor 3~~: *Education and Training.*

Note: *Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification to members.*

Element E: Verification of Work History

The organization verifies practitioners work history <u>within ~~365~~ 90 calendar days at the time of the credentialing decision</u>.

Scoring	**Met**	**Partially Met**	**Not Met**
	To be determined	To be determined	To be determined

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, factor 13. *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~365~~ 90 calendar days.

Employment dates. The organization obtains a minimum of the most recent 5 years of work history as a health professional through the practitioner's application or CV.

If the practitioner has fewer than 5 years of work history, the time frame starts at the initial licensure date.

The application or CV includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for 5 years or more with no gap. In such a case, providing the year meets the intent of this factor.

Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods (i.e., signature or initials of staff who reviewed the history and the date of review).

- *If a gap in employment exceeds 6 months,* the practitioner clarifies the gap verbally or in writing. The organization documents a verbal clarification or includes the written notice in the practitioner's credentialing file.
- *If the gap in employment exceeds 1 year,* the practitioner clarifies the gap in writing and the organization documents its review.

Element F: Verification of Malpractice History

The organization verifies a history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner within ~~180~~ <u>90 calendar days at the time of the credentialing decision.</u>

Scoring	Met	Partially Met	Not Met
	To be determined	To be determined	To be determined

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the Credentialing Committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, factor 13. *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Verification time limit: ~~180~~ 90 calendar days.

The organization obtains confirmation of the past 5 years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The 5-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.

Element G: Verification of State Licensing Sanctions

The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice <u>within 90 calendar days at the time of the credentialing decision.</u>

Scoring	Met	Partially Met	Not Met
	<u>To be determined</u>	<u>To be determined</u>	<u>To be determined</u>

Data source Records or files

Scope of review NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of verification.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Verification time limit: ~~180~~ 90 calendar days.

Each file contains evidence of verification of sanction information from a listed source and review by organization staff. Refer to CR 1, Element A, factor 13.

The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides or has provided care to members for the most recent 5-year period available. If practitioners were licensed in more than one state in the most recent 5-year period, the query must include all states in which they provided care. The organization may obtain verification from the NPDB for all practitioner types listed below.

The following sources may be used for verification:

- *Physicians:*
  - Appropriate state agencies.
  - Federation of State Medical Boards (FSMB).
- *Chiropractors*:
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
- *Oral surgeons*:
  - State Board of Dental Examiners or State Medical Board.
- *Podiatrist*s:
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
- *Other nonphysician health care professionals*:
  - State licensure or certification board.
  - Appropriate state agency.

Element H: Verification of Medicare and Medicaid Sanctions <u>and Exclusions</u>

The organization verifies practitioner's Medicare and Medicaid sanctions <u>and exclusions within 90 calendar days.</u>

Scoring	Met	Partially Met	Not Met
	To be determined	To be determined	To be determined

Data source   Records or files

Scope of review   NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For Initial Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.** This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of verification.
Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Verification time limit: ~~180~~ 90 calendar days.

Each file contains evidence of verification of sanction and exclusion information from a listed source and review by organization staff. Refer to CR 1, Element A, *Related information,* "Appropriate documentation."

The organization ~~may~~ obtains verification **~~from any~~** ~~of~~ from the following sources, as applicable:

- State Medicaid agency for all organizations that have a Medicaid line a business. ~~or intermediary~~.
- All line of business obtain verification from any of the following sources:
  - ~~Medicare intermediary.~~
    - List of Excluded Individuals and Entities maintained by OIG ~~and available over the internet~~) or FSMB.
- ~~Medicare Exclusion Database.~~
- ~~Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.~~
  - AMA Physician Master File.
- ~~FSMB.~~
  - SAM.gov
  - NPDB.

Exceptions

None.

Related information

Use of verifications in CR 5: Ongoing Monitoring. The organization may use sanctions information in CR 5, Element A, factors 1 and 2 to meet CR 3, Elements G and H ~~B~~ if the information is no more than 80~~180~~ calendar-days old and the organization provides documentation that the practitioner was enrolled in alert services at the time of the cited report.

Query results. The organization is not required to share query results with NCQA. NCQA accepts documentation of the query and of the organization's receipt of the information.

Element A: Verification of Credentials

The organization verifies that the following are within the prescribed time limits:

1. A current and valid license to practice.

2. A valid DEA or CDS certificate, if applicable.

3. Education and training as specified in the explanation.

4. Board certification status, if applicable.

5. Work history.

6. A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.

	Met	Partially Met	Not Met
Scoring	High (90–100%) on file review for at least 4 factors and medium (60–89%) on file review for any remaining factors	High (90–100%) or medium (60–89%) on file review for 6 factors	Low (0–59%) on file review for any factor

Data source Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews verification of credentials within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 36 months.

For All Surveys: For credentialing files where verification of DEA or CDS is before June 1, 2020, and a practitioner who is DEA- or CDS- eligible does not have a DEA or CDS certificate, NCQA accepts either the verification process required in the 2022 standards or the applicable prior year's standards, which state, "If a qualified practitioner does not have a valid DEA or CDS certificate, the organization notes this in the credentialing file and arranges for another practitioner to fill prescriptions."

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

For factors with verification time limits, NCQA counts back from the decision date to the verification date to assess timeliness of verification.

All credentials must be current at the time of the credentialing committee decision.

Appropriate documentation

Each file contains evidence of verification from a listed source and review by organization staff. Refer to CR 1, Element A, *Related information,* "Appropriate documentation."

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Factor 1: **Licensure**

Verification time limit: 90180 calendar days.

The organization verifies that the practitioner has a valid and current license to practice at the time of the credentialing decision. The organization verifies license in all states where the practitioner provides care to members. The organization must verify license directly from state licensing or certification agency (or its website).

Factor 2: **DEA or CDS certificates**

Verification time limit: Prior to the credentialing decision.

This factor applies to practitioners who are qualified to write prescriptions. The organization verifies that the practitioner's Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members. Acceptable verification sources:

- DEA or CDS agency.
- DEA or CDS certificate, or a photocopy of the certificate.
- Documented visual inspection of the original DEA or CDS certificate.
- Confirmation from the American Medical Association (AMA) Physician Masterfile (DEA only).
- American Osteopathic Association Official Osteopathic Physician Profile Report or Physician Master File (DEA only).
- Confirmation from the state pharmaceutical licensing agency, where applicable.

Pending DEA certificates

The organization may credential a practitioner whose DEA certificate is pending if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending until the practitioner has a valid DEA certificate.

DEA- and CDS-eligible practitioners who do not have a certificate

The organization verifies that all DEA- and CDS-eligible practitioners who do not have a valid DEA/CDS certificate, and for whom prescribing controlled substance is in the scope of their practice, have in place a designated practitioner to write prescriptions on their behalf. The organization documents the practitioner's lack of DEA/CDS certificate in the credentialing file and obtains the name of a designated alternate prescriber from the practitioner. If the alternate prescriber is a practice

~~rather than an individual, the file may include the practice name. The organization is not required to arrange an alternate prescriber.~~

~~If the practitioner states in writing that they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA/CDS certificate, but must describe their process for handling instances when a patient requires a controlled substance. The organization includes the practitioner's statement and process description in the credentialing file.~~

~~*Factor 3:* **Education and training**~~

~~*Verification time limit:* Prior to the credentialing decision.~~

~~The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate:~~

1. ~~Board certification.~~
2. ~~Residency.~~
3. ~~Graduation from medical or professional school.~~

~~Additionally, the organization verifies fellowship, if applicable.~~

~~The organization uses any of the following to verify education and training:~~

- ~~The primary source.~~
- ~~The state licensing agency, specialty board or registry, if it performs primary source verification.~~
  - ~~The organization:~~
    - ~~Obtains written confirmation at least annually from the state licensing agency, specialty licensing agency, specialty board or registry that primary-source verifies education and training information, *or*~~
    - ~~Provides a printed, dated screenshot of the state licensing agency, specialty board or registry website displaying the statement that it performs primary source verification of practitioner education and training information, *or*~~
    - ~~Provides evidence of a state statute requiring the licensing agency, specialty board or registry to obtain verification of education and training directly from the institution.~~
- ~~Sealed transcripts, if the organization provides evidence that it inspected the contents of the envelope and confirmed that the practitioner completed (graduated from) the appropriate training program.~~

~~Verification of fellowship does not meet the intent of this factor.~~

~~Future dates of program completion do not meet the intent of this factor.~~

~~**Other acceptable verification sources for physicians (MD, DO)**~~

~~*Board certification*~~

- ~~For physicians (MD, DO):~~
  - ~~ABMS or its member boards or an official ABMS Display Agent, where a dated certificate of primary-source authenticity has been provided.~~
    ~~***Note:** The ABMS "Is Your Doctor Board Certified," accessible through the ABMS website, is intended for consumer reference only and is not an acceptable source for verifying board certification.*~~
  - ~~AMA Physician Masterfile.~~

- ~~AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.~~
- ~~Boards in the United States that are not members of the ABMS or AOA (e.g., National Board of Physicians and Surgeons), if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.~~
- ~~For other health care professionals:~~
  - ~~Registry that performs primary source verification of board status, if the organization obtains annual written confirmation that the registry performs primary source verification of board certification status.~~

~~Expired board certification meets requirements because primary-source verified education and training information would not change with expiration of board certification.~~

~~Graduation from medical school~~

- ~~AMA Physician Masterfile.~~
- ~~American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or AOA Physician Master File.~~
- ~~Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986.~~

~~Completion of residency training~~

- ~~AMA Physician Masterfile.~~
- ~~AOA Official Osteopathic Physician Profile Report or AOA Physician Master File.~~
- ~~FCVS for closed residency programs.~~

~~NCQA only recognizes residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Accreditation Council for Graduate Medical Education—International, the American Osteopathic Association (in the United States), the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada.~~

~~Factor 4:~~ **~~Board certification status~~**

~~Verification time limit:~~ ~~90~~ ~~180 calendar days.~~

~~NCQA does not require board certification; however, the organization verifies current certification status of practitioners who state that they are board certified.~~

~~The organization documents the expiration date of the board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. If the expiration date is not provided, the organization may leave the expiration date blank in the practitioner file.~~

~~Verification sources~~

~~The organization uses any of the following to verify board certification:~~

- ~~For all practitioner types:~~
  - ~~The primary source (appropriate specialty board).~~

~~The state licensing agency, if it primary-source verifies board certification.~~
- ~~For physicians (MD, DO), the sources listed under *Factor 3: Education and Training.*~~

Note: *~~Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification to members.~~*

~~*Factor 5:*~~ Work history

~~Verification time limit:~~ ~~90~~ 365 ~~calendar days.~~

~~Employment dates.~~ ~~The organization obtains a minimum of the most recent 5 years of work history as a health professional through the practitioner's application or CV. If the practitioner has fewer than 5 years of work history, the time frame starts at the initial licensure date.~~

~~The application or CV includes the beginning and ending month and year for each position of employment experience, unless the practitioner has had continuous employment for 5 years or more with no gap. In such a case, providing the year meets the intent of this factor.~~

~~Gaps in work history.~~ ~~The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods (i.e., signature or initials of staff who reviewed the history and the date of review).~~
- *~~If a gap in employment exceeds 6 months,~~* ~~the practitioner clarifies the gap verbally or in writing. The organization documents a verbal clarification or includes the written notice in the practitioner's credentialing file.~~
- *~~If the gap in employment exceeds 1 year,~~* ~~the practitioner clarifies the gap in writing and the organization documents its review.~~

~~*Factor 6:*~~ Malpractice history

~~Verification time limit:~~ ~~90~~ 180 ~~calendar days.~~

~~The organization obtains confirmation of the past 5 years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The 5-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship.~~

~~Exceptions~~

~~Factors 3 and 5 are NA for recredentialing files.~~

~~Factor 4 is NA if the practitioner is:~~
- ~~Not board certified,~~ *~~or~~*
- ~~A board-certified nurse practitioner or other health care professional, but the organization does not communicate board certification to members.~~

Related information

~~Query results.~~ ~~The organization is not required to share query results with NCQA. NCQA accepts documentation of the query and of the organization's receipt of the information.~~

Examples   **DEA- and CDS-eligible practitioner who do not have a certificate**

Practitioner's statement. I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management.

Element B: Sanction Information

The organization verifies the following sanction information for credentialing:

1. State sanctions, restrictions on licensure and limitations on scope of practice.

2. Medicare and Medicaid sanctions and exclusions.

Scoring

Met	Partially Met	Not Met
High (90–100%) on file review for at least 1 factor and medium (60–89%) on file review for any remaining factor	Medium (60–89%) on file review for 2 factors	Low (0–59%) on file review for any factor

Data source   Records or files

Scope of review   **Product lines**

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews verification of sanctions information within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period   *For First Surveys:* 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of verification.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Verification time limit: ~~90~~ 180 calendar days.

~~Each file contains evidence of verification of sanction information from a listed source and review by organization staff. Refer to CR 1, Element A, *Related information,* "Appropriate documentation."~~

Factor 1: **Scope of review for sanctions and limitations on licensure**

~~The organization verifies state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides or has provided care to members for the most recent 5-year period available. If practitioners were licensed in more than one state in the most recent 5-year period, the query must include all states in which they provided care. The organization may obtain verification from the NPDB for all practitioner types listed below.~~

~~The following sources may be used for verification:~~

- ~~*Physicians:*~~
  - ~~Appropriate state agencies.~~
  - ~~Federation of State Medical Boards (FSMB).~~
- ~~*Chiropractors:*~~
  - ~~State Board of Chiropractic Examiners.~~
  - ~~Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).~~
- ~~*Oral surgeons:*~~
  - ~~State Board of Dental Examiners or State Medical Board.~~
- ~~*Podiatrists:*~~
  - ~~State Board of Podiatric Examiners.~~
  - ~~Federation of Podiatric Medical Boards.~~
- ~~*Other nonphysician health care professionals:*~~
  - ~~State licensure or certification board.~~
  - ~~Appropriate state agency.~~

Factor 2: **Sources for Medicare/Medicaid sanctions ~~and exclusions~~**

~~The organization may obtain verification from any of the following sources:~~

- ~~State Medicaid agency or intermediary.~~
- ~~Medicare intermediary.~~
- ~~List of Excluded Individuals and Entities (maintained by OIG and available over the internet).~~
- ~~Medicare Exclusion Database.~~
- ~~Federal Employees Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General.~~
- ~~AMA Physician Master File.~~
- ~~FSMB.~~
- ~~NPDB.~~

Exceptions

~~None.~~

Related information

Use of verifications in CR 5: Ongoing Monitoring. ~~The organization may use sanction information in CR 5, Element A, factors 1 and 2 (e.g., NPDB Continuous Query results) to meet CR 3, Element B if the information is no more than 180 calendar-days old and the organization provides documentation that the practitioner was enrolled in the alert services at the time of the cited report.~~

Query results. ~~The organization is not required to share query results with NCQA. NCQA accepts documentation of the query and of the organization's receipt of the information.~~

~~**Examples**~~   ~~None.~~

Element IC: Credentialing Application

Applications for credentialing include the following:

1. **Reasons for inability to perform the essential functions of the position.**

2. **Lack of present illegal drug use.**

3. **History of loss of license and felony convictions.**

4. **History of loss or limitation of privileges or disciplinary actions.**

5. **Current malpractice insurance coverage.**

6. **Practitioner race, ethnicity and language.**

7. **Current and signed attestation confirming the correctness and completeness of the application.**

	Met	Partially Met	Not Met
Scoring	High (90-100%) on file review for at least 4 factors and medium (60-89%) on file review for any remaining factors	High (90-100%) or medium (60-89%) on file review for 6 factors	Low (0-59%) on file review for any factor

Data source   Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews application and attestation within a random sample of up to 40 initial credentialing files and up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 36 months.

Explanation   **THIS IS A MUST-PASS ELEMENT.**

This element applies to:
- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Initial credentialing and recredentialing files, unless an exception noted below applies.

NCQA counts back from the decision date to the verification date to assess timeliness of credentialing and recredentialing decisions.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Appropriate documentation

Attestation verification time limit: ~~365~~90 calendar days.

Each file contains the application and attestation, and evidence of review by the organization's staff. Refer to CR 1, Element A, factor 13. *Related information,* ~~"Appropriate documentation."~~

***Factor 1:* Inability to perform essential functions**

The inquiry regarding inability to perform essential functions may vary or may exceed NCQA standards, depending on the organization's interpretation of applicable legal requirements such as the Americans with Disabilities Act (ADA).

***Factor 2:* Illegal drug use**

Practitioners may use language other than "drug" to attest they do not use illegal substances. The organization may use more general or extensive language to query practitioners about impairment; language is not required to refer exclusively to the present or only to illegal substances.

***Factor 3:* History of loss of license**

At initial credentialing, practitioners attest to any loss of license since their initial licensure. At recredentialing, practitioners attest to any loss of licensure since the last credentialing cycle.

***Factor 3:* History of felony convictions**

At initial credentialing, practitioners attest to any felony convictions since their initial licensure. At recredentialing, practitioners attest to any felony convictions since the last credentialing cycle.

***Factor 4:* Limitation of privileges or disciplinary actions**

At initial credentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since their initial licensure. At recredentialing, practitioners attest to any loss or limitation of privileges or disciplinary actions since the last credentialing cycle.

***Factor 5:* Current malpractice coverage**

The application states the amount of a practitioner's current malpractice insurance coverage (even if the amount is $0) and the date when coverage expires.

If the practitioner's malpractice insurance coverage is current and is provided in the application, it must be current as of the date when the practitioner signed the attestation and include the amount of coverage the practitioner has on the date when the attestation was signed. If the practitioner does not have current malpractice coverage, then it is acceptable to include future coverage with the effective and expiration dates.

Documentation of malpractice insurance coverage may also be a face sheet, a federal tort letter or employer professional liability policy as an addendum to the application. In this case, the practitioner is not required to attest to malpractice coverage on the application. The face sheet, federal tort letter or employer professional liability policy must include the insurance effective and expiration dates (the future effective date is acceptable).

Evidence of private malpractice insurance coverage or employer professional liability policy must include a roster of all individuals in the practice who are covered under the policy.

Evidence of a face sheet must be from the carrier, and must include the practice name and a roster of all individuals in the practice who are covered under the policy.

Evidence of federal tort coverage must include effective and expiration dates, but is not required to include a roster of all practitioners who are covered under the policy.

Factor 6: <u>Race, ethnicity and language</u>

<u>The organization includes a field on the application for race, ethnicity and language.</u>

Factor 7: **Correctness and completeness of the application**

If the application and attestation must be updated, only the practitioner may attest to the update; organization staff may not. If a copy of an application from an entity external to the organization is used, it must include an attestation to the correctness and completeness of the application. NCQA does not count the associated attestation elements as present if the practitioner did not sign the application within the required time frame.

Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file.

CAQH. CAQH has a system that allows the practitioner to update application information electronically. NCQA accepts the last attestation date generated by this system as the date when the practitioner signed and dated the application to attest to its completeness and correctness.

Exceptions

None.

Related information

Meeting time limits. NCQA does not require receipt of the attestation before the organization conducts credentialing verification and queries required for other elements. If the signature attestation exceeds the time limit before the credentialing decision, the practitioner must attest that the information on the application remains correct and complete, but is not required to complete another application. NCQA recommends that the organization send a copy of the completed application with the new attestation form when it requests the practitioner to update the attestation.

Use of other applications. The organization may use a state application or an application from another entity if it meets the factors in this element.

If state regulations require the organization to use a credentialing application that does not contain an attestation, or all information in factors 1–6̶7, the organization attaches the attestation or additional information as an addendum to the application. If state regulations prohibit addenda to the application, the organization attaches a copy of the relevant regulations when it submits the survey tool.

Examples   None.

CR 4: Recredentialing Cycle Length

The organization formally recredentials its practitioners at least every 36 months.

Intent

The organization conducts timely recredentialing.

Element A: Recredentialing Cycle Length

The length of the recredentialing cycle is within the required 36-month time frame.

Scoring

Met	Partially Met	Not Met
High (90-100%) on file review	Medium (60-89%) on file review	Low (0-59%) on file review

Data source   Records or files

Scope of review

Product lines

This element applies to Renewal Surveys for all product lines.

Documentation

NCQA reviews the timeliness of recredentialing within a random sample of up to 40 recredentialing files for practitioners that were due for recredentialing during the look-back period.

Look-back period

For Renewal Surveys: 36 months.

Explanation

THIS IS A MUST-PASS ELEMENT.

This element applies to:

- Practitioners in the scope of credentialing as defined in CR 1, Element A.
- Recredentialing files, unless an exception noted below applies.

Each file contains the Credentialing Committee decision date. The 36-month recredentialing cycle begins on the date of the previous credentialing decision. NCQA counts the 36-month cycle to the month, not to the day.

Dispute of file review results

NCQA conducts onsite file review in the presence of the organization's staff and works with the organization to resolve any disputes during the onsite survey. An organization that is unable to resolve a dispute with the survey team must contact NCQA before the onsite survey is complete. File review results may not be disputed or appealed once the onsite survey is complete.

Exceptions

None.

Related information

Extending the recredentialing cycle length. The organization may extend a practitioner's recredentialing cycle time frame (beyond 36 months) if the practitioner is:

- On active military assignment.
- On medical leave (e.g., maternity leave).
- On sabbatical.

The organization documents this and recredentials the practitioner within 60 calendar days of the practitioner's return to practice.

Termination and reinstatement. If the organization terminates a practitioner for administrative reasons (e.g., the practitioner failed to provide complete credentialing information) and not for quality reasons, it may reinstate the practitioner within 30 calendar days of termination and is not required to perform initial credentialing. The organization performs initial credentialing if reinstatement is more than 30 calendar days after termination.

If the organization does not have the necessary information for recredentialing, it informs the practitioner that this information is needed at least 30 calendar days before the recredentialing deadline and that without this information, the practitioner will be administratively terminated. The organization includes this notification in the practitioner's credentialing file. If the practitioner is subsequently terminated for lack of information, the termination notice should be in the practitioner's file.

Failure to recredential within 36 months. The organization will be scored down if it missed the 36-month time frame for recredentialing a practitioner but did not terminate the practitioner. The organization may recredential the practitioner within 30 calendar days of missing the deadline, but if recredentialing is not completed within 30 calendar days, the organization must initial credential the practitioner.

Termination of delegate. NCQA requires an unbroken string of recredentialing at least every 3 years. If an organization can obtain files from the delegate, it is not required to start over with initial credentialing; it may continue the process begun by the delegate and recredential practitioners when they are due.

If the organization cannot obtain files from the delegate, it must perform initial credentialing within 6 months of the delegate's termination date. The organization is responsible for ensuring that credentialing occurs according to NCQA standards.

Examples   None.

CR 5: Ongoing Monitoring and Interventions

The organization develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality.

Intent

The organization identifies and, when appropriate, acts on important quality and safety issues in a timely manner during the interval between formal credentialing.

Element A: Ongoing Monitoring ~~and Interventions~~

The organization implements ongoing monitoring ~~and makes appropriate interventions~~ by:

1. **Collecting and reviewing Medicare and Medicaid sanctions <u>and exclusions</u>.**

2. **Collecting and reviewing sanctions~~,~~ ~~and~~ limitations <u>and expiration</u> on licensure.**

3. **Collecting and reviewing complaints.**

4. **Collecting and reviewing information from identified adverse events.**

5. ~~**Implementing appropriate interventions when it identifies instances of poor quality related to factors 1–4.**~~

	Met	Partially Met	Not Met
Scoring	The organization meets <u>3-4</u> ~~4-5~~ factors	The organization meets <u>2</u> ~~3~~ factors	The organization meets 0-1 ~~2~~ factors

Data source   Documented process, Reports, Materials, Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures<u>.</u>~~,~~

<u>NCQA also reviews evidence of the organization's enrollment, contract, subscription to an approved source or reports obtained from the approved sources.</u> ~~and documentation of interventions throughout the look-back period.~~

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   This element applies to practitioners in the scope of credentialing as defined in CR 1, Element A.

The organization conducts ongoing monitoring between recredentialing cycles.

***Factor 1:* Sources for Medicare/Medicaid sanctions <u>and exclusions</u>**

~~The organization collects and reviews information from any of the following sources:~~

- State Medicaid agency for <u>all organizations that have a Medicaid line of business.</u> ~~or intermediary.~~

- ~~Medicare intermediary.~~
- All line of business obtain verification from any of the following sources:
  - *FEHB Program Department Record,* published by the Office of Personnel Management, Office of the Inspector General.
  - List of Excluded Individuals and Entities ~~(~~maintained by OIG)
  - FSMB
  - AMA Physician Master File
  - SAM.gov
  - NPDB.
- ~~Medicare Exclusion Database.~~
- ~~FSMB.~~
- ~~NPDB.~~

Factor 2: **Sources for sanctions and limitations and expiration on licensure**

~~The organization collects and reviews information from any of the following sources:~~

- *Physicians:*
  - Appropriate state agencies.
  - FSMB.
  - NPDB.
- *Chiropractors:*
  - State Board of Chiropractic Examiners.
  - Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Board Action Databank (CIN-BAD).
  - NPDB.
- *Oral surgeons:*
  - State Board of Dental Examiners or State Medical Board, depending on the state.
  - NPDB.
- *Podiatrists:*
  - State Board of Podiatric Examiners.
  - Federation of Podiatric Medical Boards.
  - NPDB.
- *Nonphysician healthcare practitioners:*
  - Appropriate state agency.
  - State licensure or certification board.
  - NPDB.

Factors 1, 2: **Time frame for reviewing sanction information**

~~The organization reviews information within 30 calendar days of its release by the reporting entity.~~

~~If the reporting entity does not publish sanction information on a set schedule, the organization:~~

- ~~Documents that the reporting entity does not release information on a set schedule.~~
- ~~Queries for this information at least every 6 months.~~

~~If the reporting entity does not release sanction information reports, the organization conducts individual queries of credentialed practitioners every 12–18 months.~~

~~If the organization subscribes to a sanctions alert service (e.g., NPDB Continuous Query), it~~ <u>The organization</u> reviews the information <u>from approved sources:</u>

- At least monthly.
- Within 10~~30~~ calendar days of a new alert <u>if subscribed to a continuous monitoring service (e.g., NPDB).</u>

The organization shares information with the credentialing committee based on criteria defined in CR 1, Element A: Credentialing Policies.

Factor 3: **Collecting and reviewing** ~~Investigating~~ **complaints**

The organization:

- Investigates all practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable.
- Evaluates the history of all complaints for all practitioners at least every 6 months.

Factor 4: **Adverse events**

The organization monitors for adverse events at least <u>monthly.</u> ~~every 6 months.~~

~~The organization may limit monitoring of adverse events to primary care practitioners and high-volume behavioral healthcare practitioners.~~

~~*Factor 5:* **Implementing interventions**~~

~~The organization implements interventions based on its policies and procedures if there is evidence of poor quality that could affect the health and safety of its members.~~

Exception<u>s</u>

<u>None.</u>

Factor 5 is NA if there are no sanctions, complaints or adverse events that require the organization to implement an intervention.

Examples   None.

Element B: Appropriate Interventions

The organization reports the findings from Element A to the Credentialing Committee and implements interventions as needed.

Scoring

Met	Partially Met	Not Met
<u>The organization meets the requirement.</u>	<u>No scoring option.</u>	<u>The organization does not meet the requirement</u>

<u>Data source</u>   <u>Documented process, Reports</u>

Scope of review	NCQA reviews the organization's policies and procedures for implementing appropriate interventions based on the information found in Element A. NCQA reviews credentialing committee meeting minutes and reviews reports demonstrating how the organization takes action to address ongoing monitoring findings.
Look-back period	*For First Surveys:* 6 months.
	For Renewal Surveys: 24 months.
Explanation	**THIS IS A CORE ELEMENT.** The organization must meet this requirement even if it does not have any clients or serve a delegate. This element applies to practitioners in the scope of credentialing as defined in CR 1, Element A.
	The organization follows its policies and procedures outlined in CR 1, Element A for implementing interventions based on the information found in CR 5, Element A. The organization reports the findings to its credentialing committee and documents the results of the actions proposed.

CR 6: Notification to Authorities and Practitioner Appeal Rights

An organization that has taken action against a practitioner for quality reasons reports the action to the appropriate authorities and offers the practitioner a formal appeal process.

Intent

The organization uses objective evidence and patient-care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards.

Element A: Actions Against Practitioners

The organization has policies and procedures for:

1. The range of actions available to the organization.

2. Making the appeal process known to practitioners.

Scoring	Met	Partially Met	Not Met
	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source   Documented process

Scope of review

Product lines

This element applies to Interim Surveys and First Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation   This element is a **structural requirement**. The organization must present its own documentation.

This element applies to practitioners in the scope of credentialing as defined in CR 1, Element A.

Factor 1: **Range of actions available**

Policies and procedures:
- Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare.
- Specify the range of actions that may be taken to improve practitioner performance before termination.
- Specify that the organization reports its actions to the appropriate authorities.

Factor 2: **Making the appeal process known**

No additional explanation required.

Exceptions

None.

Examples   None.

CR 7: Assessment of Organizational Providers

The organization has written policies and procedures for the initial and ongoing assessment of providers with which it contracts.

Intent

The organization evaluates the quality of providers with which it contracts.

Element A: Review and Approval of Provider

The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it:

1. Confirms that the provider is in good standing with state and federal regulatory bodies.

2. Confirms that the provider has been reviewed and approved by an accrediting body.

3. Conducts an onsite quality assessment if the provider is not accredited.

Scoring	Met	Partially Met	Not Met
	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source   Documented process

Scope of review

Product lines

This element applies to Interim Surveys and First Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation

An **organizational provider** is a facility that provides services to members, and where members are directed for services rather than to a specific practitioner. This element applies to all organizational providers with which the organization contracts (e.g., telemedicine providers, urgent care centers, durable medical equipment entities).

Factor 1: **Confirmation with state and federal regulatory bodies**

The organization's policies and procedures specify sources used to confirm that providers are in good standing with state and federal requirements, including:

- Applicable state or federal agency.
- Agent of the applicable state or federal agency.
- Copies of credentials (e.g., state licensure) from the provider.

NCQA does not accept an attestation from a provider to the organization regarding the provider's regulatory status.

Factor 2: **Confirmation of review and approval by an accrediting body**

The organization's policies and procedures specify sources used to confirm the provider's accreditation status, including:

- Applicable accrediting body for each type of organizational provider
- Agent of the applicable accrediting body.
- Copies of credentials (e.g., accreditation report, certificate or decision letter) from the provider.

NCQA does not accept an attestation from a provider to the organization regarding the provider's accreditation status.

Factor 3: **Site visits for unaccredited facilities**

The organization's policies and procedures include:

- Onsite quality assessment criteria for each type of provider.
- A process ensuring that the providers credential their practitioners.

The organization receives credit for this factor if its policies and procedures specify that it contracts only with accredited providers.

If a provider has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

State or federal review in lieu of a site visit

The organization may have a policy to substitute a CMS or state quality review in lieu of a site visit under the following circumstances:

- The CMS or state review is no more than 3 years old.
  - If the CMS or state review is older than 3 years, the organization conducts its own onsite quality review.
- The organization obtains a survey report or letter from CMS or the state, from either the provider or the agency, stating that the facility was reviewed and passed inspection.
  - The report meets the organization's quality assessment criteria or standards.

The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

Exceptions

None.

Related information

Time frame. NCQA does not prescribe a time frame for gathering data to use for assessing organizational providers (e.g., the 180-calendar-day rule, applied against the verification of credentials of individual practitioners, is NA).

Examples   None.

Element B: Medical Providers

The organization includes at least the following medical providers in its assessment:

1. Hospitals.*

2. Home health agencies.

3. Skilled nursing facilities.

4. Free-standing surgical centers.

**Critical factors: Score cannot exceed Partially Met if one critical factor is scored "no."*

	Met	Partially Met	Not Met
Scoring	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 0-1 factors

Data source   Documented process

Scope of review

Product lines

This element applies to Interim Surveys and First Surveys for all product lines.

Documentation

NCQA reviews an organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation   Factor 1 is a critical factor; if this critical factor is scored "no" the organization's score cannot exceed "Partially Met" for this element.

Factors 2–4

No additional explanation required.

Exception

Factors 1–4 are NA if the organization does not contract with any of the provider types in factors 1–4.

Related information

Nonskilled home health agencies. Home health agencies that only provide home aides (e.g., for help with cooking, dressing, medical appointments) are not within the scope of CR 7.

Examples   None.

Element C: Behavioral Healthcare Providers

The organization includes behavioral health care facilities providing mental health or substance abuse services in the following settings:

1. Inpatient.

2. Residential.

3. Ambulatory.

	Met	Partially Met	Not Met
Scoring	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process

Scope of review

Product lines

This element applies to Interim Surveys and First Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

Explanation

Assessment policies and procedures address all applicable types of providers, regardless of how many members are treated at the facilities.

The organization is not required to credential organizational providers that operate only as 12-step programs.

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

Factor 2 is NA if residential treatment facilities are not part of the organization's benefit package or are unavailable in the service area.

Factors 1–3 are NA if the organization does not contract with any of the provider types in factors 1–3.

Examples

Behavioral healthcare providers

- Psychiatric hospitals and clinics.
- Addiction disorder facilities.
- Residential treatment centers for psychiatric and addiction disorders.

Element D: Assessing Medical Providers

The organization assesses contracted medical health care providers against the requirements and within the time frame in Element A.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source   Reports, Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence that the organization assessed the providers in Element B. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

Exceptions

None.

Table 1: Assessment of organizational providers tracking log

Organization Name	Organization Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	Accrediting Body	Site Visit
Mega	Hospital	4/1/2021; Active	4/10/2021; Name; Active	Rural provider, visit not conducted by state or CMS.
		4/5/2024; Active	4/15/2024; Name; Active	Rural provider, visit not conducted by state or CMS.
Downtown Surgery Center	Free-Standing Surgical Center	3/2/2021 Active	None	2/10/2021; CMS Compliant
		3/15/2024; Active	None	2/2/2024; CMS Compliant
District Physicians	Home Health	3/2/2021; Active	3/20/2021; Name; Active	Rural provider, visit not conducted by state or CMS.

Organization Name	Organization Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	Accrediting Body	Site Visit
		3/17/2024; Active	3/20/2024; Name; Active	Rural provider, visit not conducted by the state or CMS.

Element E: Assessing Behavioral Healthcare Providers

The organization assesses contracted behavioral healthcare providers against the requirements and within the time frame in Element A.

Scoring

Met	Partially Met	Not Met
The organization meets the requirement	No scoring option	The organization does not meet the requirement

Data source   Reports, Records or files

Scope of review

Product lines

This element applies to First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews evidence that the organization assessed the providers in Element C. The organization provides documentation of a tracking mechanism(s) (checklist or spreadsheet); a separate tracking mechanism or report is not required for each provider.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation   The organization is not required to conduct a site visit if the provider is in a rural area, as defined by the U.S. Census Bureau (https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html), and the state or CMS has not conducted a site review.

The organization is also not required to conduct a site visit of ambulatory facilities that are not part of the organization's benefits package or are not available in the service area.

Exceptions

This element is NA if all purchasers of the organization's services carve out or exclude behavioral healthcare.

The organization provides evidence to support the score of "NA."

Examples

Table 2: Assessment of behavioral healthcare organizational providers tracking log

Organization Name	Organization Type	Confirmation Dates and Statuses		
		Licensing & Regulatory	**Accrediting Body**	**Site Visit**
Mega X	Ambulatory	4/1/2021; Active	4/10/2021; Name; Active	NA
		4/5/2024; Active	4/15/2024; Name; Active	NA
Getting Better	Residential	3/2/2021; Active	None	2/2/2021; CMS Compliant
		3/15/2024; Active	None	2/10/2024; CMS Compliant

CR 8: Credentialing Information Integrity

The organization has credentialing information integrity policies and procedures, audits credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.

Intent

The organization demonstrates its commitment to protecting the integrity of credentialing information used in the credentialing process.

Element A: Protecting the Integrity of Credentialing Information

The organization has credentialing information integrity policies and procedures that specify:

1. **Scope of credentialing information.**

2. **Staff responsible for performing credentialing activities.**

3. **The process for documenting updates to credentialing information.**

4. **Inappropriate documentation and updates.**

5. **The process for documenting and reporting identified information integrity issues.**

Scoring

Met	Partially Met	Not Met
The organization meets 5 factors	No scoring option	The organization meets 0-4 factors

Data source   Documented process

Scope of review

Product lines

This element applies to All Surveys for all product lines.

Documentation

NCQA reviews the organization's policies and procedures for protecting the integrity of credentialing information.

Look-back period   *For All Surveys:* Prior to the survey date.

Explanation   This element may not be delegated.

This element applies to credentialing information (both paper and electronic) used in the credentialing process (CR 2–CR 5).

Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

The organization's credentialing information integrity policies and procedures may be separate, or may be incorporated in other organization policies and procedures.

Factor 1: **Scope of credentialing information**

The organization's policies and procedures specify that the organization protects the integrity of the following credentialing information:

- The practitioner application and attestation.
- Credentialing documents received from the source or agent.
- Documentation of credentialing activities:
  - Verification dates.
  - Report dates.
  - Credentialing decisions.
  - Credentialing decision dates.
  - Signature or initials of the verifier or reviewer.
- Credentialing Committee minutes.
- Documentation of clean file approval, if applicable.
- Credentialing checklist, if used.

Factor 2: **Staff responsible for performing credentialing activities**

The organization's policies and procedures:

- Specify titles of staff who are:
  - Responsible for documenting credentialing activities.
  - Authorized to modify (edit, update, delete) credentialing information.
    - Policies and procedures state if no staff are authorized to modify credentialing information under any circumstances.
  - Responsible for oversight of credentialing information integrity functions, including the audit.

Factor 3: **Process for documenting updates to credentialing information**

The organization's policies and procedures:

- Specify when updating credentialing information is appropriate (e.g., to update expiring credentials).
- Describe the organization's process for documenting the following when updates are made to credentialing information:
  - When (date and time) the information was updated.
  - What information was updated.
  - Why the information was updated.
  - Staff who updated the information.

Factor 4: **Inappropriate documentation and updates**

The organization's policies and procedures:

- Specify that the following documentation and updates to credentialing information are inappropriate:
  - Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
  - Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as new credential).
  - Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
  - Attributing verification or review to an individual who did not perform the activity.
  - Updates to information by unauthorized individuals.

Factor 5: **Auditing, documenting and reporting information integrity issues**

The organization's policies and procedures:

- Specify that the organization audits credentialing staff documentation and updates.
  - The organization does not have to include the audit methodology, but must indicate that an annual audit is performed.
- Describe the process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified, and
  - NCQA, when it identifies fraud and misconduct.
    - Refer to Section 5 *(Reporting Hotline for Fraud and Misconduct; Notifying NCQA of Reportable Events)* in the Policies and Procedures for additional details.
- Specify consequences for inappropriate documentation and updates.

Examples   None.

Element B: Information Integrity Training

The organization trains credentialing staff on the following, upon hire and annually thereafter:

1. **Inappropriate documentation and updates (Element A, factor 4).**

2. **Organization audits of staff, documenting and reporting information integrity issues (Element A, factor 5).**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source   Reports, Materials

Scope of review **Product lines**

This element applies to all surveys for all product lines.

Documentation

For All Surveys, NCQA reviews training materials and reports demonstrating that the organization conducted the required trainings for credentialing staff upon hire and annually.

Look-back period   *For All Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

Factor 1: **Inappropriate documentation and updates**

The organization trains credentialing staff on inappropriate documentation and updates to credentialing information, as defined in Element A, factor 4.

Factor 2: **Auditing, documenting and reporting information integrity issues**

The organization's training informs credentialing staff of:
- Organization audits of staff documentation and updates in credentialing files.
- The process for documenting and reporting inappropriate documentation and updates to:
  - The organization's designated individual(s) when identified.
  - NCQA, when the organization identifies fraud and misconduct.
- The consequences for inappropriate documentation and updates.

Exceptions

None.

Examples *None.*

Element C: Audit and Analysis

The organization annually:

1. **Audits for inappropriate documentation and updates to credentialing information.**

2. **Conducts qualitative analysis of inappropriate documentation and updates.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Reports

Scope of review **Product lines**

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys: NCQA reviews the organization's audit and analysis reports completed during the look-back period.

Look-back period *For First and Renewal Surveys:* At least once during the prior year.

Explanation **THIS IS A MUST-PASS ELEMENT.**

This element may not be delegated.

Factor 1: **Audit**

The organization annually audits credentialing verifications, decisions and ongoing monitoring (CR 2–CR 5) for the following inappropriate documentation and updates:
- Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
- Creating documents without performing the required activities.
- Altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).

- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

The audit universe includes practitioner files for all initial credentialing decisions and all recredentialing decisions made or due during the look-back period. The organization randomly audits a sample of practitioner files from the audit universe using 5% or 50 files, whichever is less.

The random sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed within the look-back period, the organization audits all files. The organization may choose to audit more practitioner files than NCQA requires.

The organization provides an auditing and analysis report that includes:
- The date of the report.
- The title of staff who conducted the audit.
- The audit method:
  - Audit period.
  - Audit universe size.
  - Audit sample size.
  - File identifier (individual practitioner).
  - Type of credentialing information audited (e.g., licensure).
- Findings for each file.
  - A rationale for inappropriate documentation and updates (Element A, factor 4).
- The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The organization must provide a completed audit report even if no inappropriate documentation and updates were found.

Factor 2: Qualitative **analysis**

The organization annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause.

The organization's auditing and analysis report includes:
  - Titles of credentialing staff involved in the analysis.
  - The cause of each finding.

Refer to *Appendix 5: Glossary* for the full definition of qualitative analysis.

Exceptions

This element is NA for *Interim Surveys.*

Factor 2 is NA if the organization did not identify any inappropriate documentation and updates (factor 1). NCQA assesses whether this conclusion is reasonable, based on results of the organization's analysis.

Examples   **Excerpt from audit and analysis report**

Factor 1: **Audit sampling**

Each January, the organization's credentialing director audits for inappropriate documentation and updates to credentialing information for the previous calendar year. The audit includes the following information:

- Credentialing verifications (CR 3).
- Credentialing decisions (CR 2, CR 4).
- Ongoing monitoring process (CR 5).

The organization randomly samples and audits 5% or 50 files (whichever is less) of all credentialing decisions made or due in the previous year.

- *Audit period:* January–December of the previous year.

Identify the universe. The organization initial credentialed 2,000 practitioners, and recredentialed 8,000 practitioners who were due for recredentialing in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 10,000 practitioner files.

Calculate the sample size. Multiply the total number of files in the universe by 5% (10,000 files x 0.05 = 500 files).

Randomly select files for the sample, for a total of 50 files:

- 20 initial credentialing files.
- 30 recredentialing files.

Audit the selected file sample. The organization audits the files for inappropriate documentation and updates, and documents findings.

Factor 1: **Audit log**

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Practitioner ID	File Type (Initial/Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner 1	Recredential	No		NA
Practitioner 2	Initial	No		NA
Practitioner 3	Recredential	Yes	Attestation	Attestation date updated by staff (name) instead of practitioner because attestation was expiring. 3/3/XX @ 2:59 PM
Practitioner 4	Recredential	Yes	Licensure Sanction Information	Verification of licensure and sanction information updated by staff (name) without going to the source (3/3/XX @ 11:00 AM) because the committee meeting was scheduled for the next day.

Factors 1, 2: **Audit report and analysis**

Methodology

- Frequency: Annual (January).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

*Sample **calculation***

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit findings and analysis. The organization audited a random sample of 50 files that included 20 initial credentialing files and 30 recredentialing files.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	4	4	16%
License	2	2	8%
DEA/CDS	0	0	0%
Education and Training	0	NA	0%
Board Certification Status	0	0	0%
Work History	4	NA	8%
Malpractice History	0	0	0%
Sanction Information	2	2	8%
Credentialing Committee Minutes	0	4	8%
Clean-File Approvals	0	0	0%
Ongoing Monitoring Reports	0	0	0%
Total	12	6	36%

Qualitative analysis. The credentialing analyst provided the credentialing director with the audit log documenting when, how, why and by whom files were updated.

The credentialing director met with credentialing staff (credentialing assistant director, credentialing manager, credentialing analyst) to determine the cause of noncompliance with credentialing integrity policies and procedures.

Credentialing Information	Description of Noncompliant Update	Reason
Application and Attestation	Attestation date updated by staff instead of practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.
License	Verification was updated without going to the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.
Sanction Information	Verification was updated without going to the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.
Credentialing Committee Minutes	Four practitioners were added to Credentialing Committee minutes without actually being presented to the Committee.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Organization leadership instructed staff to update minutes to reflect that the practitioners approved in the prior Credentialing Committee meeting.

Element D: Improvement Actions

The organization:

1. **Implements corrective actions to address all inappropriate documentation and updates found in Element C.**

2. **Conducts an audit of the effectiveness of corrective actions (factor 1) on findings 3–6 months after completion of the annual audit in Element C.**

Scoring

Met	Partially Met	Not Met
The organization meets 2 factors	No scoring option	The organization meets 0-1 factors

Data source Documented process, Reports, Materials

Scope of review Product lines

This element applies to all product lines for First Surveys and Renewal Surveys.

Documentation

For First and Renewal Surveys:

- *For factor 1: NCQA reviews* the organization's documentation of corrective actions planned or taken to address inappropriate documentation and updates.
- *For factor 2:* NCQA reviews the organization's audit of the effectiveness of corrective actions.

Look-back period *For First and Renewal Surveys:* At least once during the prior year.

Explanation   This element may not be delegated.

The organization addresses credentialing information integrity issues identified in Element C.

Factor 1: **Implement corrective actions**

The organization documents corrective actions taken or planned, including dates of actions, to address all inappropriate documentation and updates (findings) identified in Element C. One action may address more than one finding, if appropriate. The organization may not use trainings (Element B) as the only action.

The organization identifies staff (by title) who are responsible for implementing corrective actions.

Factor 2: **Measure of effectiveness follow-up audit**

The organization audits the effectiveness of corrective actions (factor 1) on findings within 3–6 months of the annual audit completed for Element C. and draws conclusions about the actions' overall effectiveness. The audit universe includes practitioner files for all credentialing decisions made or due to be made 3–6 months after the annual audit.

The organization conducts a qualitative analysis if it identifies noncompliance with integrity policies and procedures during the follow-up audit.

Exceptions

This element is NA for *Interim Surveys.*

This element is NA if the organization did not identify any inappropriate documentation and updates, according to the audit and analysis report reviewed for Element C. NCQA assesses whether this conclusion is reasonable, based on results in the organization's audit and analysis report.

Factor 2 is NA if the annual audit is less than 3 months before the organization's NCQA Survey.

Examples   **Excerpt from report on corrective actions and measures of effectiveness**

Factor 1: **Corrective actions**

The organization implemented immediate corrective actions to address noncompliant updates after sharing audit and analysis results with credentialing staff and organization leadership. Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

Credentialing Information/ Noncompliant Update	Reason	Actions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.	Educate staff on the organization's policies and procedures. [Date] Train staff on NCQA's documentation requirements. [Date] Establish automated resending of attestation to practitioner 60 days before expiration. [Date]

Credentialing Information/ Noncompliant Update	Reason	Actions
License: Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.	Require credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Date]
Sanction Information: Verification was not updated from the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.	Incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Date] Purchase software application to automatically retrieve verification from accepted sources (web crawler). [Date]

Factor 2: **Effectiveness of corrective actions audit**

The organization audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings from the previous annual audit.

Methodology

- Audit staff: Names, titles.
- Frequency: Six months (June).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The organization reviewed a random sample of 20 initial credentialing files and 30 recredentialing files.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	0	0	0%
License	0	0	0%
Sanction Information	0	0	0%
Total	0	0	0%

Conclusions about the actions' overall effectiveness

Credentialing Information/ Noncompliant Update	Actions	Conclusions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Educate staff on organization policies and procedures. [Date] Train staff on NCQA documentation requirements. [Feb] Establish automated resending of attestation to practitioner 60 days before expiration. [Mar]	Staff completed the required training and new automated system upgraded to resend attestation to practitioner 60 days before expiration. These actions have eliminated updating of attestation by staff. The were no incidences identified in audit.
License: Verification was not updated from the source. **Sanction Information:** Verification was not updated from the source.	Require credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Feb] Incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Mar] Purchase software application to automatically retrieve verification from accepted sources (web crawler). [Apr]	Staff and leadership completed the required ethics training. Incorporated system flag that does not allow updating information without going to the source and confirmation functionality. Purchased software application to automatically retrieve verification from accepted sources (web crawler). The were no incidences identified in audit.

The correction implemented has been effective overall; the audit did not identify incidents of inappropriate documentation and update.

CR 9: Delegation of CR

If the organization delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for credentialing and recredentialing its practitioners and for protecting credentialing/recredentialing information integrity, even if it delegates all or part of credentialing activities.

Element A: Delegation Agreement

The written delegation agreement:

1. **Is mutually agreed upon.**

2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**

3. **Requires at least semiannual reporting by the delegated entity to the organization.**

4. **Describes the process by which the organization evaluates the delegated entity's performance.**

5. **Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making.**

6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

	Met	Partially Met	Not Met
Scoring	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 0-2 factors

Data source   Documented process

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

Documentation

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For factor 4:

- New delegation agreements implemented on or after July 1, 2025, must address the delegate's credentialing information integrity.

- Delegation agreements in place prior to July 1, 2025, that address the system controls under the 2022–2024 standards do not need to be updated to address credentialing information integrity requirements. NCQA does not evaluate the agreement against system controls requirements in prior years.

- Delegation agreements in place prior to July 1, 2025, that do not address the system controls intent under the 2022–2024 standards must be updated to address credentialing information integrity requirements.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months for factors 1–6.

For Renewal Surveys: 24 months for factors 1–6.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

The delegation agreement describes all delegated credentialing activities. A generic policy statement about the content of delegated arrangements does not meet this element.

Factor 1: **Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

NCQA considers the effective date specified in the delegation agreement as the mutually agreed-upon effective date. The effective date may be before or after the signature date on the agreement. If the agreement has no effective date, NCQA considers the signature date (the date of the last signature) as the mutually agreed upon effective date.

NCQA may accept other evidence of the mutually agreed-upon effective date: a letter, meeting minutes or other form of communication between the organization and the delegate that references the parties' agreement on the effective date of delegated activities.

NCQA requires submitted evidence for all other delegation factors to consider the same mutually agreed-upon date as the effective date for the delegate's performance of delegated activities.

Factor 2: **Assigning responsibilities**

The delegation agreement, an addendum thereto or other binding communication between the organization and the delegate specifies credentialing activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
  - The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other credentialing functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify which organization is responsible for oversight of the subdelegate.

Factor 3: **Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about delegated activities.

- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited delegates. NCQA scores this factor "yes" if the organization delegates credentialing activities to an NCQA-Certified CVO that is certified to perform the delegated activity.

Factor 4: **Performance monitoring**

The delegation agreement states the organization's process for monitoring and evaluating the delegate's performance, as required in Element C, including credentialing information integrity.

Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates, as outlined in CR 8, Element A, factor 4.

If the organization delegates any credentialing functions or activities covered in CR 2–CR 5, the delegate protects the integrity of the credentialing information used in the credentialing process. The delegation agreement specifies that the following documentation and updates to credentialing information are inappropriate:

- Falsifying credentialing dates (e.g., licensure date, credentialing decision date, staff verifier date, ongoing monitoring dates).
- Creating documents without performing the required activities (e.g., photocopying a prior credential and updating information as new credential).
- Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

Factor 5: **Right to approve, suspend and terminate**

No additional explanation required.

Factor 6: **Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that result in revocation of the agreement.

Exception

This element is NA if the organization does not delegate credentialing activities.

Related information

Outsourcing credentialing data storage to a cloud-based entity. It is not considered delegation if the organization only outsources credentialing data storage to a cloud-based entity that does not provide services that create, modify or use the credentialing data.

Examples   ### *Factor 3:* **Reporting for delegation of credentialing**
- Lists of credentialed and recredentialed practitioners.
- Committee meeting minutes.
- List of providers assessed.

Element B: Predelegation Evaluation

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

Met	Partially Met	Not Met
The organization evaluated delegate capacity before delegation began	The organization evaluated delegate capacity after delegation began	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

Product lines

This element applies to Interim Surveys, First Surveys and Renewal Surveys for all product lines.

This element applies if delegation was implemented in the look-back period.

Documentation

NCQA reviews the organization's predelegation evaluation from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation This element may not be delegated.

NCQA-Accredited/Certified delegates

Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, or are NCQA Accredited in CR or NCQA-Certified CVOs, unless the element is NA. NCQA-Certified CVOs must be certified to perform the activity delegated by the organization.

Note: *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*

- *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
- *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation. The evaluation may include a review of the organization's structure, processes and staffing in order to determine its capability to perform the delegated function.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional credentialing activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate credentialing activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples   **Predelegation evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of Delegate's Credentialing Activities

For delegation arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's credentialing policies and procedures.**

2. **Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect.**

3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**

4. **Semiannually evaluates regular reports, as specified in Element A.**

5. **Annually audits each delegate's credentialing files for inappropriate documentation and inappropriate updates to credentialing information.**

6. **Implements a corrective actions for each delegate that addresses all inappropriate documentation and inappropriate updates found in factor 5.**

7. **Conducts an audit of the effectiveness of corrective actions (factor 6) on the findings for each delegate 3–6 months after completion of the annual audit for factor 5.**

Scoring

Met	Partially Met	Not Met
The organization meets 6-7 factors	The organization meets 4-5 factors	The organization meets 0-3 factors

Data source   Reports

Scope of review	**Product lines**
	Factor 1 applies to Interim Surveys for all product lines.
	All factors in this element apply to First Surveys and Renewal Surveys for all product lines.
	Documentation
	NCQA reviews evidence of the organization's review from up to four randomly selected delegates, or from all delegates if the organization has fewer than four.
	For All Surveys: NCQA reviews the organization's evaluation of the delegate's credentialing policies and procedures (factor 1).
	For First Surveys: NCQA also reviews the organization's most recent semiannual evaluation, annual review, audits, performance evaluation, corrective actions and measure of effectiveness (factors 2–7).
	For Renewal Surveys:
	• *Factors 2–4:* NCQA also reviews the organization's most recent and the previous year's annual reviews, audits, performance evaluations and four semiannual evaluations.
	• *Factors 5–7:* NCQA also reviews the organization's most recent annual audit, performance evaluation, corrective actions and measure of effectiveness.
	The score for the element is the average of the scores for all delegates.
Look-back period	*For Interim Surveys and First Surveys:* At least once during the prior year.
	For Renewal Surveys: 24 months for factors 1–4; at least once during the prior year for factors 5–7.
Explanation	This element may not be delegated.
	NCQA-Accredited/Certified delegates
	Automatic credit is available for factors 2 and 3 if all delegates are NCQA Accredited health plans or MBHOs, NCQA Accredited in CR or NCQA-Certified CVOs, unless delegated credentialing requirements were not in scope or were scored NA during the delegates' NCQA survey.
	NCQA-Certified CVOs must be certified to perform the activity delegated by the organization.
	Automatic credit for factor 4 is available for NCQA-Certified CVOs that are certified to perform the delegated activity.
	Automatic credit is available for factors 5–8 if the organization all delegates are NCQA Accredited under the 2025 standards or later.
	***Note:** For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:*
	• *NCQA-Accredited/Certified delegates are eligible for automatic credit.*
	• *Non-Accredited/Certified delegates are reviewed and scored accordingly.*

Factor 1: **Review of credentialing policies and procedures**

The appropriate organization staff or committee reviews the delegate's credentialing policies and procedures. At a minimum, the organization reviews the sections of the policies and procedures that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates credentialing, it audits the delegate's credentialing and recredentialing files against NCQA standards. The organization uses one of the following methods to audit the files:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately.
  - The sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits all files.
- The NCQA "8/30 methodology" available at https://www.ncqa.org/ programs/health-plans/policy-accreditation-and-certification/

The organization bases its annual audit on the responsibilities of the delegate described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

For delegates that are NCQA Accredited in CR, the only NCQA-required reporting is the names or files of practitioners or providers processed by the delegate.

Factor 5: **Annual audit of credentialing information integrity**

If the organization delegates the any credentialing activities covered in CR 2–CR 5, the organization or the delegate annually audits (as applicable) the delegate's credentialing files for inappropriate documentation and updates to:

- The application and attestation.
- Credentialing documents received from the source or agent.
- Documentation of completion of credentialing activities:
  - Verification dates.
  - Report dates.
  - Credentialing decision dates.
  - Signature or initials of the verifier or reviewer.
- Credentialing checklist, if used.

Inappropriate documentation and inappropriate updates. The following are inappropriate documentation and updates:

- Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
- Creating documents without performing the required activities.
- Altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).

- Attributing verification or review to an individual who did not perform the activity.
- Updates to information by unauthorized individuals.

For each delegate, the audit universe includes practitioner files processed by the delegate for all initial credentialing decisions made and recredentialing decisions made or due to be made within the look-back period.

Because the organization may have several credentialing delegates, the audit uses one of the following methods:

- 5% or 50 files, whichever is less, to ensure that information is verified appropriately.
  - The sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files.
- The NCQA "8/30 methodology" available at https://www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Either methodology is allowed, for consistency with other delegation oversight requirements for annual file audits.

The organization or delegate may choose to audit more practitioner files than NCQA specifies.

The organization provides an auditing and analysis report for each delegate that includes:

- The date of the report.
- Title of staff who conducted the audit.
- The audit method:
  - Audit period.
  - Audit universe size.
  - Audit sample size.
- File identifier (individual practitioner).
- Type of credentialing information audited (e.g., licensure).
- Findings for each file.
  - Draw a conclusion if inappropriate documentation and updates occur (Element A, factor 2).
- The number or percentage and total inappropriate documentation and updates by type of credentialing information.

The delegate or organization must provide a completed audit report even if no inappropriate finding were found.

If the organization uses the delegate's audit results, it must provide evidence (e.g., report, meeting minutes) that it reviewed and evaluated the delegate's findings.

Factor 6: **Implement corrective actions**

For each delegate with inappropriate documentation and updates (findings) identified in factor 5, the organization documents corrective actions taken or planned, including the time frame for actions, to address all findings identified in factor 5. One action may be used to address more than one finding, if appropriate.

The organization's corrective action plan identifies staff (by title) who are responsible for implementing corrective actions.

Factor 7: **Measure effectiveness of actions audit**

The organization or delegate audits the effectiveness of corrective actions (factor 6) on findings for each delegate within 3–6 months of the annual audit completed for factor 5.

For each delegate, the audit universe includes practitioner files processed by the delegate for all initial credentialing decisions made and for recredentialing decisions made or due to be made 3–6 months after the annual audit.

The organization or delegate conducts an qualitative analysis if it identifies integrity during the follow-up audit.

If the organization uses the delegate's audit results, the organization must provide evidence (e.g., a report, meeting minutes, other evidence) that it reviewed and evaluated the delegate findings.

The organization draws conclusions on the overall effectiveness of corrections implemented.

Exceptions

The element is NA if:

- The organization does not delegate credentialing activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if no practitioners were initial credentialed or were due for recredentialing.

Factors 2–7 are NA for Interim Surveys.

Factors 5–7 are NA if the delegate only provides cloud-based credentialing data storage functions and does not provide services that create, modify or use credentialing data.

Factors 6–7 are NA if the organization's annual audit of all delegates' credentialing files did not identify any inappropriate documentation and updates to credentialing information used in the credentialing process. This must be evident in reports reviewed for factor 5.

Factor 7 is NA if the timing of the organization's annual audit is less than 3 months before the organization's NCQA Survey.

Related information

Use of collaborative. The organization may collaborate in a statewide, annual file audit and evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Auditing CVOs. The organization is not required to audit CVOs against timeliness requirements during the delegation audit, because NCQA does not recognize CVOs for decision making. If the organization delegates decision making, NCQA assesses the organization for timeliness of the credentialing decision.

Oversight of national delegates. NCQA allows a national corporate office to perform credentialing oversight of a nationally contracted delegate on behalf of its affiliated organizations (accreditable entities). Oversight results must be available for each accreditable entity survey. The organization reviews 75 randomly selected files across all Accreditable entities.

If the delegate's credentialing system is not centralized, separate oversight audits must be conducted for each accreditable entity.

Examples   *Factor 2:* **Annual evaluation**

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Factor 5: **Excerpt from audit and analysis report**

Audit sampling

Each January, the delegate's credentialing director audits for inappropriate documentation and updates to credentialing information for the previous calendar year. The audit includes the following information:

- Credentialing verifications (CR 3).
- Credentialing decisions (CR 2, CR 4).
- Ongoing monitoring process (CR 5).

The delegate randomly samples and audits 5% or 50 files (whichever is less) of all credentialing decisions made or due in the previous year.

- *Audit period:* January–December of the previous year.

Identify the universe. The delegate initial credentialed 2,000 practitioners, and recredentialed 8,000 practitioners who were due for recredentialing in the previous year.

- *Audit date:* January [date].
- *Sample universe:* 10,000 practitioner files.

Calculate the sample size. Multiply the total number of files in the universe by 5% (10,000 files x 0.05 = 500 files).

Randomly select files for the sample, for a total of 50 files:

- 20 initial credentialing files.
- 30 recredentialing files.

Audit the selected file sample. Audit the files for inappropriate documentation and updates, and document findings.

Audit log

Audit date: January [date, year].

Audit period: January–December of the previous year.

Audit staff: Names, titles.

Practitioner ID	File Type (Initial/ Recred)	Inappropriate Documentation/ Updates?	Credential Affected	Finding
Practitioner ABC	Recredential	No		NA
Practitioner DEF	Initial	No		NA
Practitioner GHI	Recredential	Yes	Attestation	Attestation date updated by staff (name) instead of practitioner because attestation was expiring. 3/3/XX @ 2:59 PM
Practitioner XYZ	Recredential	Yes	Licensure Sanction Information	Verification of licensure and sanction information updated by staff (name) without going to the source (3/3/XX @ 11:00 AM) because the committee meeting was scheduled for the next day.

Audit report and analysis

Methodology

- Frequency: Annual (January).
- Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.
- Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

- File universe = 10,000 files.
- 5% or 50 files calculation = 10,000 x .05 = 500 files.
- Minimum sample size = 50 files.

Audit findings and analysis. The delegate reviewed a random sample of 20 initial credentialing files and 30 recredentialing files with modifications.

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	4	4	16%
License	2	2	8%
DEA/CDS	0	0	0%
Education and Training	0	NA	0%
Board Certification Status	0	0	0%
Work History	4	NA	8%
Malpractice History	0	0	0%
Sanction Information	2	2	8%

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Credentialing Committee Minutes	0	4	8%
Clean-File Approvals	0	0	0%
Ongoing Monitoring Reports	0	0	0%
Total	12	6	36%

Qualitative analysis. The credentialing analyst provided the credentialing director with the audit log documenting when, how, why and by whom files were updated.

The delegate's credentialing director met with credentialing staff (credentialing assistant director, credentialing manager, credentialing analyst) to determine the cause of noncompliance with credentialing integrity policies and procedures.

Credentialing Information	Description of Noncompliant Update	Reason
Application and Attestation	Attestation date updated by staff instead of practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.
License	Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification.
Sanction Information	Verification was not updated from the source.	Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.
Credentialing Committee Minutes	Four practitioners were added to Credentialing Committee minutes who did not attend the meeting.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Organization leadership instructed staff to update minutes to reflect that the practitioners attended the Credentialing Committee meeting.

Excerpt from reports of corrective actions and measures of effectiveness

Factor 6: **Corrective actions**

The organization required the delegate to implement immediate corrective actions to address information integrity issues after sharing audit and analysis results with credentialing staff and organization leadership.

Leadership required completion of corrective actions, outlined in the table below, on or before March [date, year].

Credentialing Information/ Noncompliant Update	Reason	Actions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Staff spoke with the practitioner, who stated that all information remained accurate. Staff did not know that only the practitioner can update the information.	Educate delegate's staff on organization policies and procedures [Date] Train delegate's staff on NCQA's documentation requirements. [Date] Delegate to establish automated resending of attestation to practitioner 60 days before expiration. [Date]
License: Verification was not updated from the source. **Sanction Information:** Verification was not updated from the source.	Staff responsible for verification of licensure and sanction information was on emergency leave and did not complete verification. Because temporary staff did not have time to complete verification of all practitioners, they copied existing credentials, changed dates and uploaded the information into the CR system before the Credentialing Committee meeting.	Require delegate's credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Date] Require delegate to incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Date] Require delegate to purchase software application to automatically retrieve verification from accepted sources (web crawler). [Date]
Credentialing Committee Minutes: Four practitioners were added to Credentialing Committee minutes who did not attend the meeting.	The organization initially terminated the practitioners for not updating their application and attestation. After 30 days, practitioners returned the required document. Delegate's leadership instructed its staff to update minutes to reflect that the practitioners attended the Credentialing Committee meeting.	Require delegate's leadership and credentialing staff to undergo ethics training, with emphasis on following credentialing information integrity policies and procedures. [Date] Require delegate to establish read only records for minutes and other credentialing information. [Date]

*Factor 7: M*easure of effectiveness audit

The delegate audits the effectiveness of actions taken in 6 months, using the method described in the report of inappropriate findings, from the previous annual audit.

Methodology

Audit staff: Names, titles.

Frequency: 6 months (June).

Audit sample: Sample practitioner files using NCQA "5% or 50 files" method.

Universe: All practitioner initial credentialing and recredentialing files.

Sample calculation

File universe = 10,000 files.

5% or 50 files calculation = 10,000 x .05 = 500 files.

Minimum sample size = 50 files.

Audit log: Not shown.

Audit findings and analysis. The delegate audited a random sample of 20 initial credentialing files and 30 recredentialing files and shared the audit finding and analysis on [date].

Credentialing Information Reviewed	Noncompliant Initial Credentialing Files	Noncompliant Recredentialing Files	Percentage of Noncompliant Modifications
Application and Attestation	0	0	0%
License	0	0	0%
Sanction Information	0	0	0%
Credentialing meeting minutes	0	0	0%
Total	0	0	0%

Conclusions on the actions' overall effectiveness

Credentialing Information/ Noncompliant Update	Actions	Conclusions
Application and Attestation: Attestation date updated by staff instead of by practitioner.	Delegate to educate staff on organization policies and procedures. [Date] Delegate to train staff on NCQA documentation requirements. [Feb] Delegate to establish automated resending of attestation to practitioner 60 days before expiration. [Mar]	Delegate's staff completed the required training [Date] and new automated system upgraded [Date] to resend attestation to practitioner 60 days before expiration. These actions have eliminated updating of attestation by staff. The were no incidences identified in audit.

Credentialing Information/ Noncompliant Update	Actions	Conclusions
License: Verification was not updated from the source.	Delegate's credentialing staff to undergo ethics training, with emphasis on following organization processes even if under pressure to take shortcuts. [Feb]	Delegate's staff and leadership completed the required ethics training. [Date]
	Delegate to incorporate system flag that does not allow updating information without going to the source and require to confirm that the information was received from the source. [Mar]	Incorporated system [Date] flags that does not allow updating information without going to the source and confirmation functionality.
Sanction Information: Verification was not updated from the source.		Purchased software application [Date] to automatically retrieve verification from accepted sources (web crawler).
	Delegate to purchase software application to automatically retrieve verification from accepted sources (web crawler) [Apr]	The were no incidences identified in audit.
Credentialing Committee Minutes: Four practitioners were added to Credentialing Committee minutes who did not attend the meeting.	Delegate's leadership and credentialing staff to undergo ethics training, with emphasis on following credentialing information integrity policies and procedures. [Date]	Delegate's leadership and credentialing staff completed ethics training [Date] and credentialing information integrity policies and procedures training. [Date]
	Delegate to establish read only records for minutes and other credentialing information. [Date]	Delegate updated [system name] to read only records for minutes and all other credentialing information. [Date]

The organization reviewed and evaluated the delegate's audit results and analysis report on [date]. The corrective actions implemented have been effective overall; the audit did not find incidents inappropriate documentation and update.

Element D: Opportunities for Improvement

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

Met	Partially Met	Not Met
The organization has acted on identified problems, if any, at least once in each of the past 2 years that the delegation arrangement has been in effect	The organization took inappropriate or weak action, or acted only in the past year	The organization has not acted on identified problems

Data source   Documented process, Reports, Materials

Scope of review	**Product lines** *This element applies to First Surveys and Renewal Surveys for all product lines.* **Documentation** NCQA reviews reports of opportunities for improvement, from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues. *For First Surveys:* NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities. *For Renewal Surveys:* NCQA reviews the organization's most recent and the previous year's annual reviews and follow-up on improvement opportunities. The score for the element is the average of the scores for all delegates.
Look-back period	*For First Surveys:* At least once during the prior year. *For Renewal Surveys:* 24 months.
Explanation	This element may not be delegated. This element does not apply to credentialing information integrity requirements, which are addressed in CR 9, Element C, factors 5–7. **NCQA-Accredited/Certified delegates** Automatic credit is available for this element if all delegates are NCQA-Accredited health plans or MBHOs, NCQA Accredited in CR or NCQA-Certified CVOs, unless the element is NA. NCQA-Certified CVOs must be certified to perform the delegated activity. ***Note:*** *For organizations that have both NCQA-Accredited/Certified and non-Accredited/Certified delegates:* • *NCQA-Accredited/Certified delegates are eligible for automatic credit.* • *Non-Accredited/Certified delegates are reviewed and scored accordingly.* **Identify and follow up on opportunities** The organization uses information from its predelegation evaluation, ongoing reports or annual evaluation to identify areas of improvement. **Exceptions** This element is NA if: • The organization does not delegate credentialing activities. • Delegation arrangements have been in effect for less than 12 months. • The organization has no opportunities to improve performance. − NCQA evaluates whether this conclusion is reasonable, given assessment results.
Examples	None.